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# Illinois Medical Journal

THE OFFICIAL JOURNAL OF

## The Illinois State Medical Society

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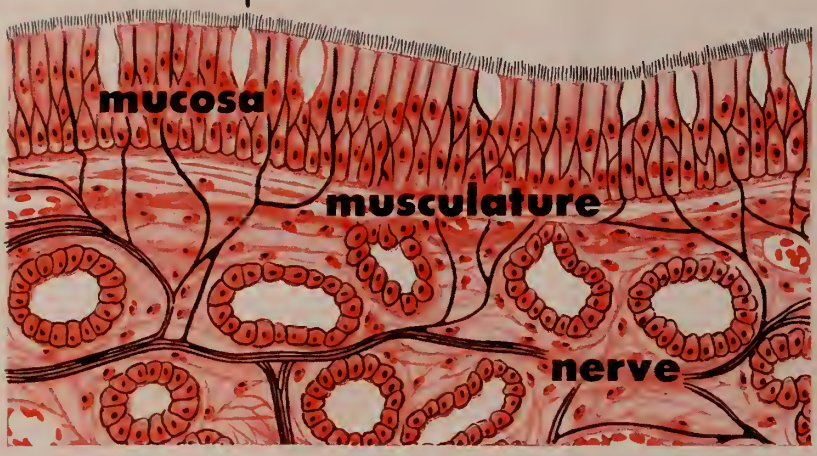
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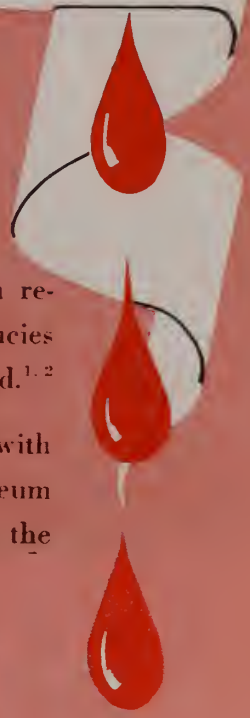
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1. E. W. Roberts, *Urol. & Cutan. Rev.*, 47:286, 1943

2. F. E. Lane, *West. J. Surg.*, 52:313, 1941

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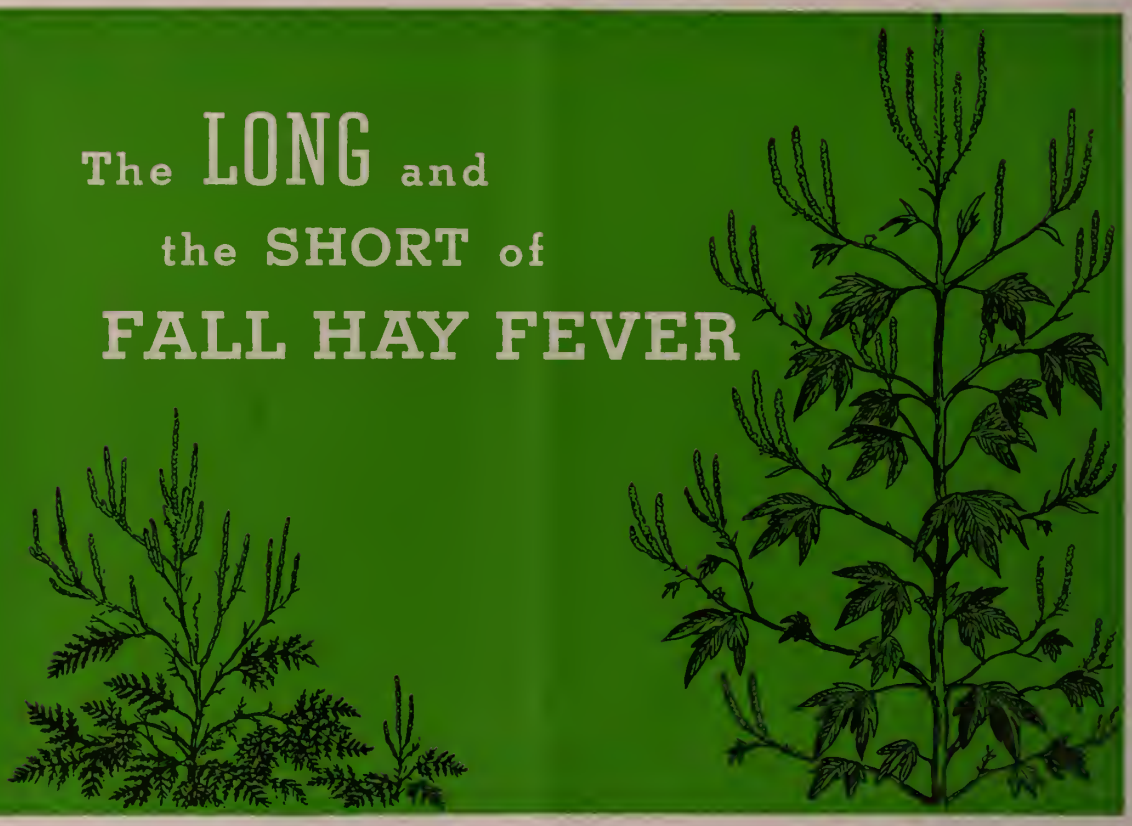
(1) Soule, S. D.: Am. J. Obst. & Gynec. 42:1009, 1941. (2) Mason, L. W.: Am. J. Obst. & Gynec. 44:630, 1942.
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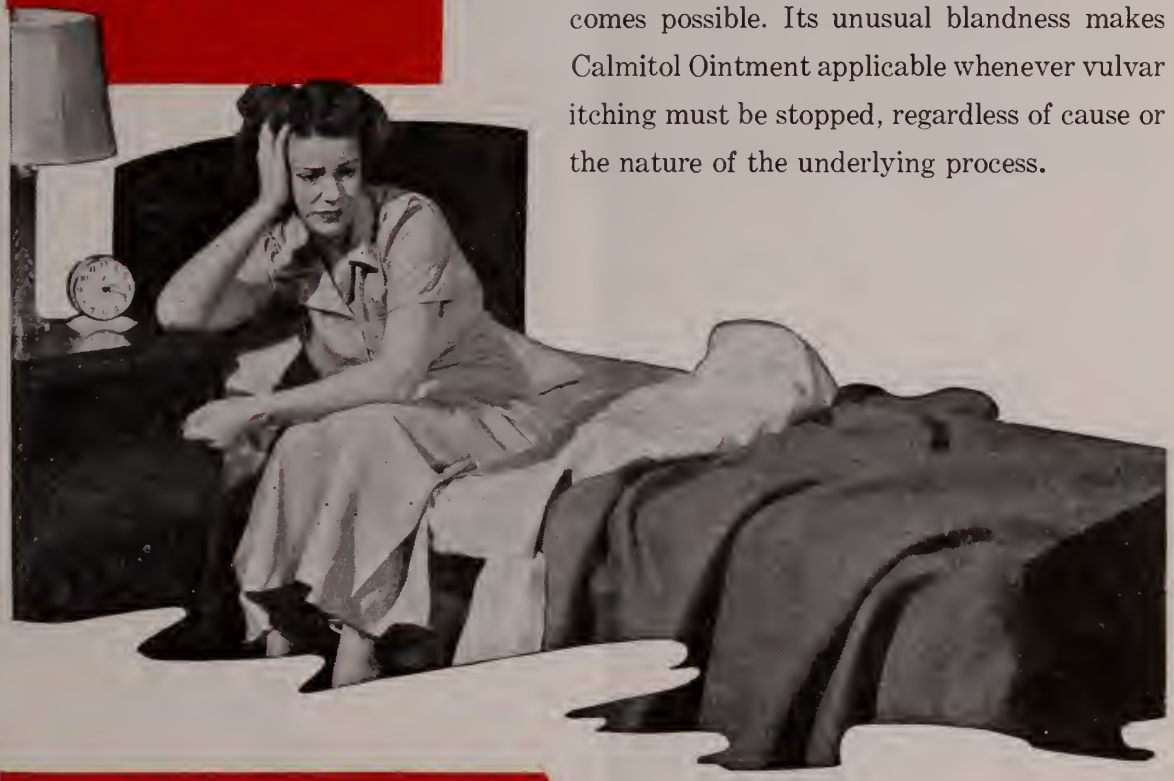
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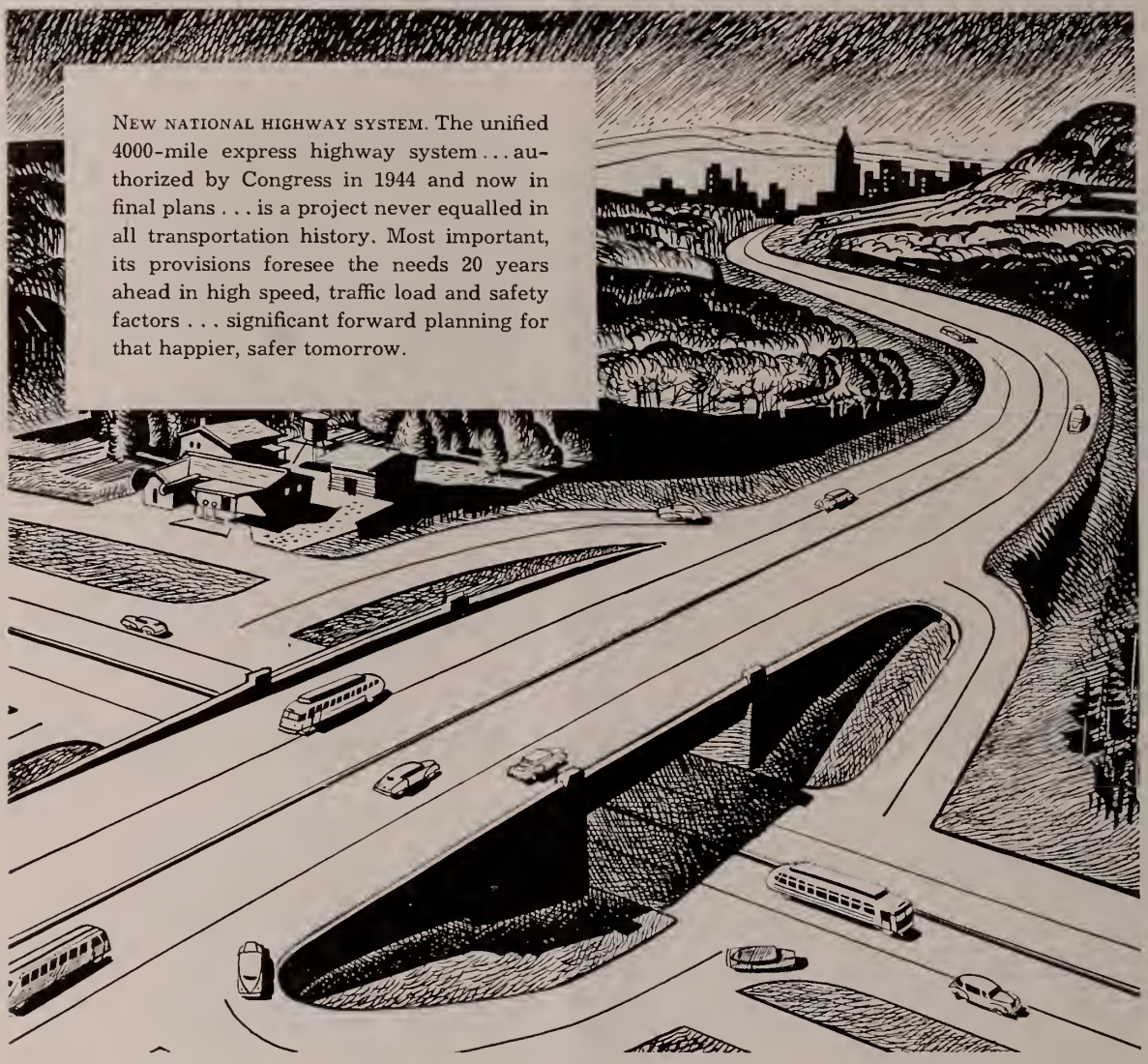
*Quart. Bull. Northwestern Univ. Med. School, 16:179, 1942.

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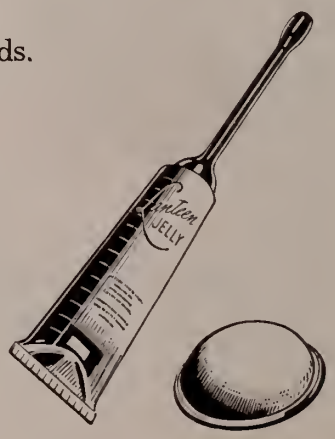
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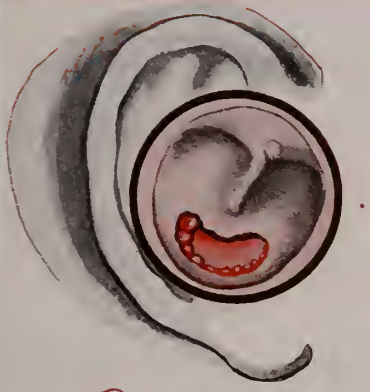
Pain, fever, edema, leucocytosis, sense of fullness and impaired hearing.

*Treatment*

Relief of pain and inflammation—*Auralgan.*

*Action*

Decongestant, analgesic, bacteriostatic.



## Otosmosan

**in CHRONIC SUPPURATIVE OTITIS MEDIA**

*Symptoms*

Persistent discharge, often foul smelling, usually no toxemia, no pain, no fever.

*Treatment*

*Otosmosan.*

*Formula*

Sulfathiazole carbamide 20% in glycerol (Doho).

*Action*

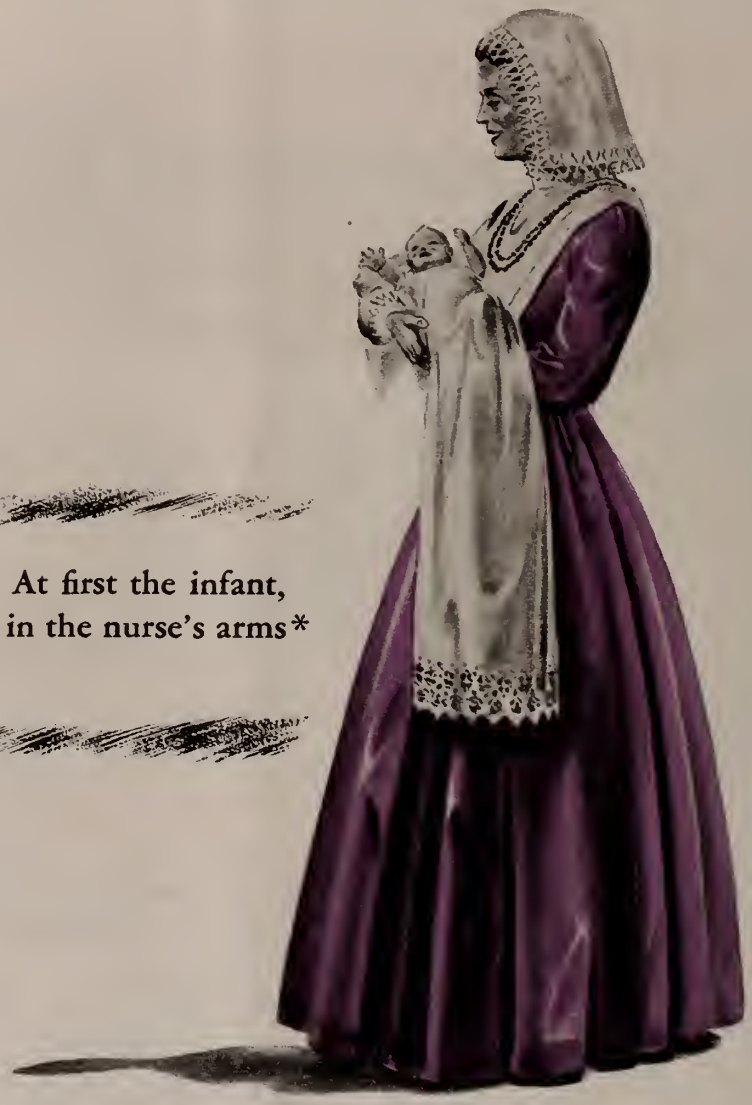
Deodorizes the discharge, liquifies unhealthy granulations, bacteriostatic, permits normal epithelialization.

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*Complimentary quantities for clinical trial*

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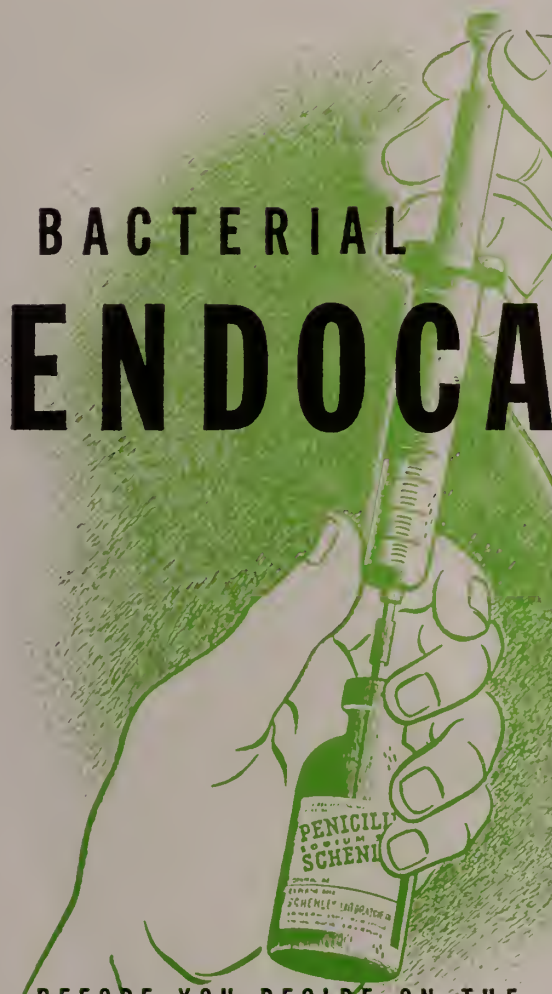
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---

DAWSON, M. H., AND HUNTER, T. H.: *The Treatment of Subacute Bacterial Endocarditis with Penicillin: Results in Twenty Cases, J.A.M.A. 127:129 (Jan. 20) 1945*... FAVOUR, C. B.; JANEWAY, C. A.; GIBSON, J. G., II, AND LEVINE, S. A.: *Progress in the Treatment of Subacute Bacterial Endocarditis, New England J. Med. 234:71 (Jan. 17) 1946.*

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(1) *Lennox, W. G. (1945), Petit Mal Epilepsies: Their Treatment With Tridione, J. Amer. Med. Assn., 129:1069, December 15.*
(2) *DeJong, R. N. (1946), Effect of Tridione in the Control of Psychomotor Attacks, J. Amer. Med. Assn., 130:565, March 2.*

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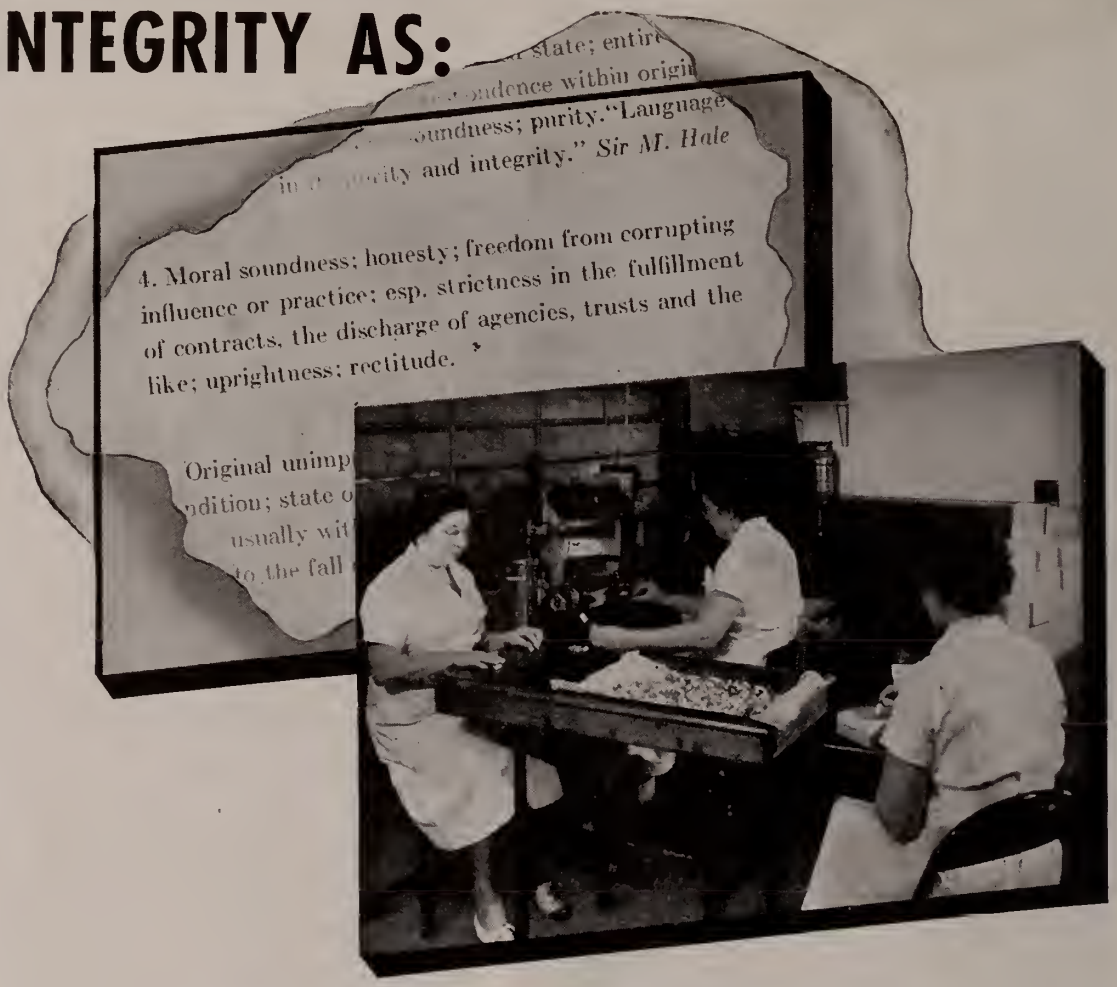
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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32, 241; N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.*




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| Niacinamide | 10 mg. |
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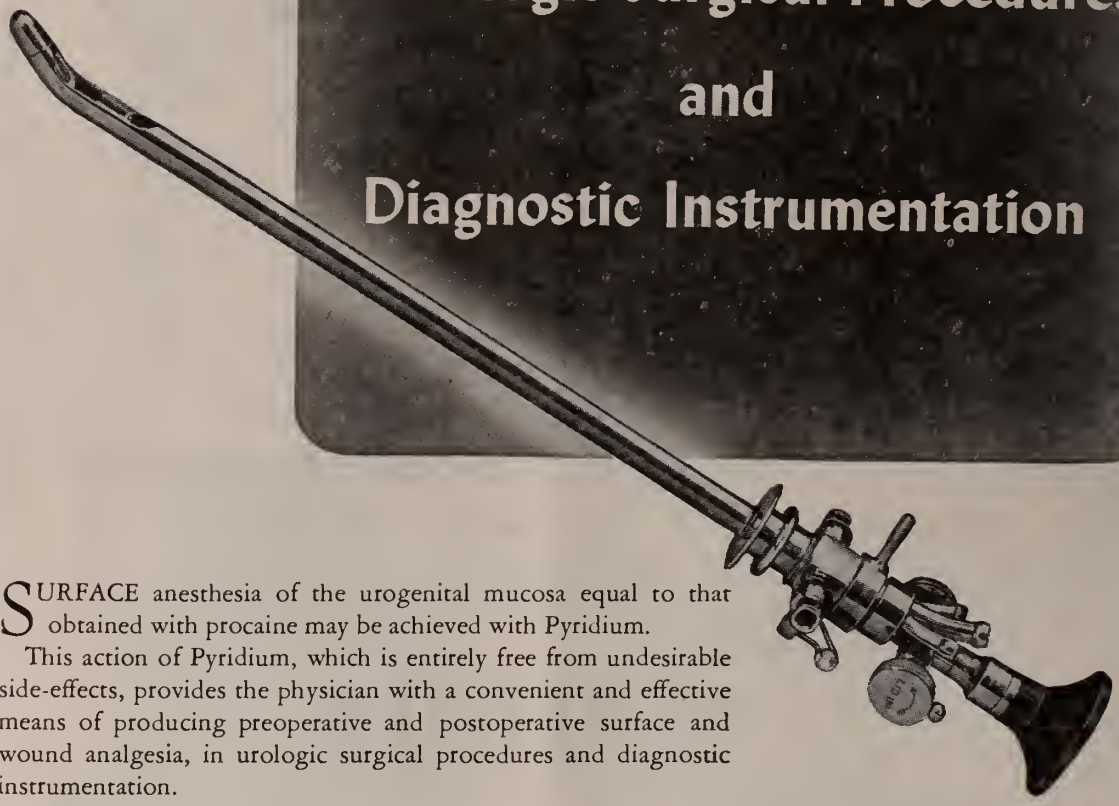
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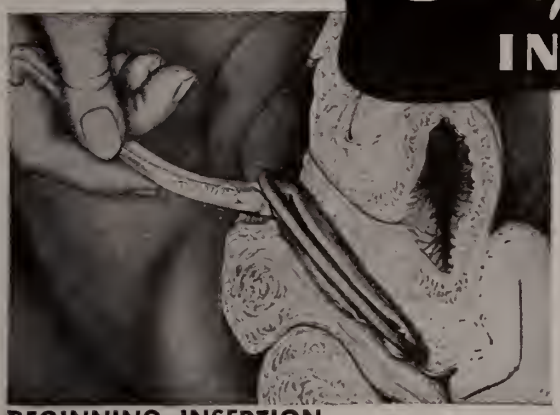
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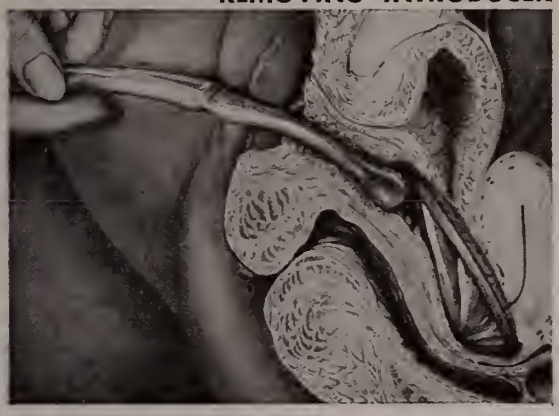


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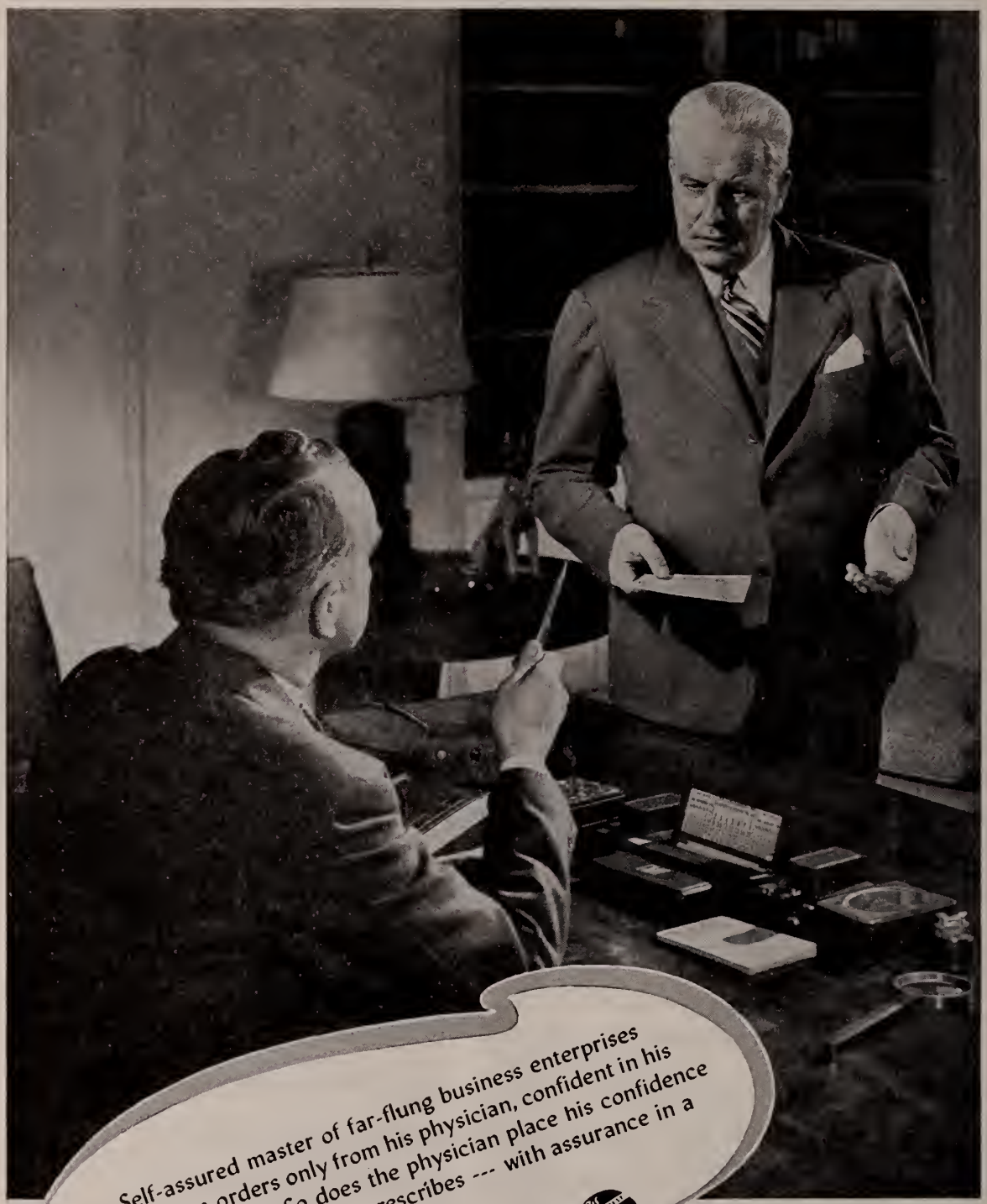
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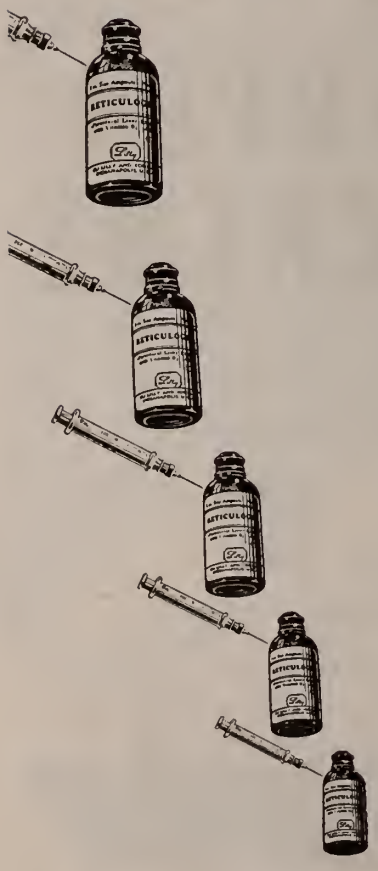
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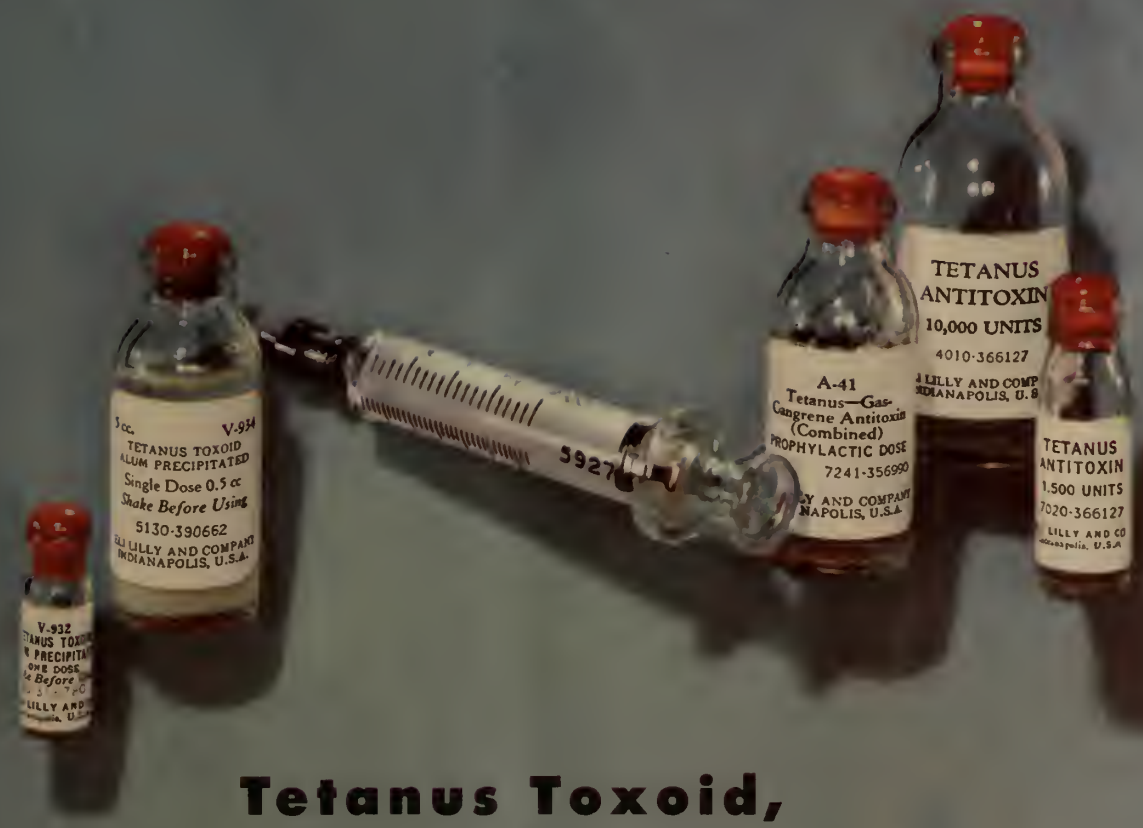

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# *Far into the night*

THERE is little rest for the busy physician even after the responsibilities to his patients have been satisfactorily discharged. Medical journals subsist entirely on the writings of physicians. The articles, designed for the purpose of sharing knowledge with others, require arduous toil, and time not available during office hours. It is well to remember then, in reading medical journal papers, that some physician somewhere may have worked far into the night with the hope that his colleagues would benefit.

A similar responsibility is attendant upon the activities of the manufacturer who makes the therapeutic agents which physicians prescribe. Eli Lilly and Company long has sought to disseminate helpful knowledge through the medium of its scientific staff, and through the personal calls of the largest and perhaps the best-informed detail staff the pharmaceutical world has ever known. This system of personal calls, established generations ago, will be continued as long as it proves of mutual benefit.

*A picture of The Good Samaritan provided the inspiration that*



*eventually led to the founding of Eli Lilly and Company*

The Illinois Medical Journal

July, 1946

VOL. 90, NO. 1

Official Journal of the Illinois State Medical Society

EDITOR — Harold M. Camp. EDITORIAL BOARD — James H. Hutton, Chairman, Frederick H. Falls
Josiah J. Moore, Edwin M. Miller, Chauncey C. Maher, Harry S. Gradle,
Harry Culver, Walter Stevenson, Raymond W. McNealy.

# Editorials

## INDOCTRINATION COURSE FOR APPLICANTS TO COUNTY MEDICAL SOCIETY MEMBERSHIP

Realizing that medical students in our modern educational institutions fail to get but little more than an outline of the important subject, medical ethics, and even less concerning many of the current problems in medical economics, the Los Angeles County Medical Society recently ruled that candidates for membership should be required to attend a course of lectures designed to indoctrinate them in certain aspects of the successful practice of medicine.

Among the subjects to be presented at these indoctrination courses are those pertaining to the medical practice act and other laws affecting the practice of medicine, malpractice prophylaxis, professional ethics and courtesy, history of the state medical association, its accomplishments and aims, and other similar related subjects. Information is to be given relative to laws governing the use and handling of narcotics, those governing birth, death and other certificates, as well as other problems which come under legal supervision.

The county medical society as the basic unit of our medical organizations throughout the country is the logical place to give such instructions and this experiment in the state of California will no doubt be of interest to medical societies throughout the entire country and most likely will be placed in action elsewhere in the near future. Membership in the county and state medical societies as well as in the American Medical Association should not be considered too lightly and the duties and responsibilities of individual members should be given more serious consideration than has been the case in the past.

As the sole judge of the qualifications of its members, the county society has the authority to require prospective members to become more familiar not only with existing laws governing medical care within the respective states, but also to be sure that they become more familiar with current medical economic problems, ethics, and their proper relationship to their confreres. Prospective members will be more aware of the fact that membership in the county society is more than a privilege, but literally a coveted asset, and well worth working for.

This experiment on the part of the Los Angeles County Medical Association will be watched with much interest by the many other component county units elsewhere and it is quite probable within the next few years, that a similar indoctrination course will be established elsewhere, and when the plan is universally adopted, there will be fewer mal-practice suits, infractions of the medical practice and narcotic laws, and unquestionably a better understanding on the part of the physicians relative to their relations with fellow practitioners, all of which are highly desirable.

## PRIZES TO BE AWARDED FOR BEST JOURNAL ARTICLES

At a recent meeting of the Editorial Board of the Illinois Medical Journal, it was recommended that prizes be awarded each year for the best articles received for publication in the Journal. Members of this Society should be encouraged to write scientific articles for publication or scientific editorials as they may prefer. After a considerable amount of discussion it was generally agreed that the Council would be asked to approve this proposal, and that two classes be made.

1. For the best written article or editorial to be passed upon by literary and scientific people.
2. For the outstanding piece of original work to be reported as a scientific paper or an editorial.

For the first class, a prize of $100.00 to be awarded to the one approved by the Committee on Awards. For the second class, a prize of $200.00 to be awarded each year. The Committee on Awards for this purpose to be the Editorial Board and for the first class, also one literary professor from one of the Universities of this state, and one outstanding newspaper writer to be selected later by the Editorial Board.

At the June meeting of the Council, this proposal was reported by the Chairman of the Editorial Board, and the Council unanimously approved the proposal, and the contest is on. Open to all members of the Illinois State Medical Society, papers now on hand which have not been published and others to be received during the present fiscal year will be considered by the Committee on Awards, and the announcement of the winners for the first year will be made at the 1947 annual meeting by the Chairman of the Editorial Board.

The Journal will carry more scientific editorials during the present fiscal year, and these will be given every consideration by the Committee on Awards in addition to the original articles received for publication.

This action in addition to its being published in The Illinois Medical Journal will also be publicized through the 92 component county med-


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ical societies, so that the announcement may be carried in all society medical bulletins as well as being reported to the individual society secretaries, to be reported at their own meetings.

We hope that members of this Society will keep this in mind and all papers received or remaining unpublished at this time will be eligible for consideration by the special committee to which the responsibility of judging the papers and editorials has been allocated.

## JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION

Volume 1, number 1 of the new Journal of the American Medical Women's Association has just been received, and we offer our congratulations and best wishes to those in this fine organization who have made another of their dreams come true. As the first issue of this journal is dated April, 1946, it is most fitting indeed, that it be dedicated as a cancer number as April has been designated as Cancer Month through the United States by action of Congress and proclamation of the President.

The editor of the new journal is Elise S. L'Esperance, M.D., New York City, and upon the editorial board we note three members of the Illinois State Medical Society, Carroll L. Birch, Beulah Cushman, and Gladys H. Dick, all of Chicago. Dr. Cushman is also Secretary of the Association. Among the scientific articles published in this journal, we find the following subjects and authors: Cancer Prevention Clinics, Catherine McFarland, M.D.; Basic Facts Regarding X-Ray and Radium Therapy, Edith H. Quimby, Sc.D.; The Urinary Tract in Pelvic Cancer, Faith S. Fetterman, M.D.; The Chicago Cancer Prevention Clinics, Augusta Webster, M.D. and others; and Report on Field Army of the American Cancer Society, Evelyn Blewett.

The Annual Meeting of the American Medical Women's Association will be held in San Francisco June 28-30, preceding the Annual Meeting of the American Medical Association, and there will no doubt be a good attendance. With more than 600 medical women in Illinois, most of whom are members of the Illinois State Medical Society, the physicians of Illinois will be interested in the future of this fine organization. They had been recognized for a number of years within our own State Medical Society and have scheduled the Annual Meetings of the Illinois Branch, No. 17, in connection with our own annual meetings.

Many physicians will be interested in the future of this fine journal and there will be, no doubt, many contributions in the future made by Illinois women physicians, and members of the Illinois State Medical Society.

## SCIENTIFIC EXHIBITS AWARDS AT THE ANNUAL MEETING

It was a difficult job for the committee on awards to determine the scientific exhibits which were deemed best in their respective classes at the recent annual meeting of the Illinois State Medical Society, as there were more exhibits than have been previously shown at the annual meetings. After a careful inspection of all exhibits the committee awarded the following prizes.

Group 1. Illustrating Original Work.

Silver Medal; Walter S. Priest, Jacques Smith, Charles J. McGee and Eugene Hildebrand; "Antibiotic Therapy of Subacute Bacterial Endocarditis".

Bronze Medal: Robert H. Herbst, James W. Merricks; "Transurethral Drainage of Seminal Vesicles; Catheterization and Dilatation of the Ejaculatory Ducts".

Certificate of Merit; A. A. Mertz; "Fractures of the Hip".

Certificate of Merit; M. Herbert Barker and R. B. Capps; "Infectious Hepatitis".

Group II. Exhibits of Exceptional Educational Value.

Silver Medal; Frederick H. Falls and Miss Charlotte S. Holt; "Puerperal Sepsis".

Bronze Medal; Caroll L. Birch and Louis R. Limarzi; "Hematology".

Certificate of Merit; Paul H. Holinger, Edwin F. Hirsch and Albert H. Andrews, Jr.; "Bronchogenic Carcinoma".

Certificate of Merit; Leon Unger and Isabella Brandt; "Allergic Conditions — Diagnosis and Treatment".

Certificate of Merit; Irving Treiger; "Corelative Study of Cardiac Diseases".

The medals and Certificates of Merit will be ordered immediately and be sent to the winners in the very near future. Prizes awarded for scientific exhibits at the 1944 annual meeting

(*Continued on page 4*)

# Correspondence

## 125 FELLOWSHIPS IN PUBLIC HEALTH ANNOUNCED

Announcement is made by Surgeon General Thomas Parran of the U. S. Public Health Service that a grant for the establishment of 125 Fellowships to train physicians and sanitary engineers in public health has just been approved by the National Foundation for Infantile Paralysis.

Each Fellowship provides a year's graduate training in a school of public health or a school of sanitary engineering. The Fellowships will be administered by the Committee on Training of Public Health Personnel, which consists of representatives of schools of public health, the State and Territorial Health Officers, the American Public Health Association and the U. S. Public Health Service.

The Fellowships are available either during the academic year beginning in the fall of 1946 or the fall of 1947, and are open to men and women, citizens of the United States under 45 years of age.

The purpose of the Fellowships is to aid in the recruitment of trained health officers, directors of special medical services, and public health engineers to help fill some of the 900 vacancies in public health medical positions and 300 vacancies for public health engineers, existing in State and local health departments over the country. The Fellowships are reserved for newcomers to the public health field, and are not open to employees in State and local health departments, for whom Federal Grants-in-Aid are already available to the States.

Applicants for Fellowships may secure further details by writing to the Surgeon General, U. S. Public Health Service, Attention: Public Health Training, 19th and Constitution Avenue N.W., Washington 25, D. C. Owing to the anticipated heavy enrollment in graduate schools, completed applications for training in the fall term of 1946 should be filed promptly. The awards committee will act on applications on the following dates: June 15, July 1, July 15 and August 1.

## AMERICAN CONGRESS OF PHYSICAL MEDICINE MEETS IN SEPT.

The American Congress of Physical Medicine will hold its twenty-fourth annual scientific and clinical session September 4, 5, 6 and 7, inclusive, at the Hotel Pennsylvania in New York. Scientific and clinical sessions will be given each day. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

## SCIENTIFIC EXHIBITS (Continued)

were never sent to the winners, as it was impossible during the war to procure medals and certificates. Those winning medals and certificates at the 1944 annual meeting will therefore receive them within a short time as they too will be ordered immediately.

Plans are now under way for the 1947 annual meeting which will likewise be held in the Palmer House, and with a different arrangement. There will be recesses in the mid-forenoon and mid-afternoon for all to visit the exhibits, which will give a much larger attendance among the many exhibits and add to their value as an important part of the annual meeting.

# Medical Economics

The Medical Economics Committee — Chauncey C. Maher, Chmn., 6 North Michigan Avenue, Chicago, Edwin S. Hamilton, V. Thomas Austin, Emmet B. Bay, Jay McDonald Milligan, Jacob M. Mora, George Halperin, Marie Wessels, Thomas C. Browning, Roland R. Cross, Milton E. Bitter, Edwin F. Hirsch, Ford Hick, Lt. Col. MC, William J. Bryan, John R. Vonachen.

## MEDICAL PRACTICE OF THE FUTURE

The practice of medicine is destined to have a number of dramatic changes in the next decade, but of particular interest is the decided trend toward specialization rather than general practice. In the past the general practitioners have exceeded the specialists in number and also have had the major share of medical practice. Many factors have been active in promoting a gradual change in this ratio of many general practitioners to few specialists toward a situation where the specialists will predominate.

Specialization after World War I was accomplished in a number of ways, usually by an informal method. A young physician acquired a general practice and gradually evolved, as his experience accumulated, into the specialty practice which he preferred, surgery, obstetrics, internal medicine or other fields. Special training was acquired on occasion by post-graduate study abroad or in the U. S., by preceptorship with an established specialist or large clinic, or self-education in a given field in a medical school dispensary.

A more formal specialty education was afforded by the large clinics, particularly the Rochester and Cleveland groups in the mid-western area and in a few University hospitals.

As the specialist's field widened, the A.M.A. took recognition of the desirability of standardization and set up American Boards, to define who should qualify as a specialist and specified training programs for the new candidates. These Boards were given power to certify those physicians who were already engaged in specialty practice, as competent and to certify new members by formal examination.

Prior to World War II, however, there was a limited number of training areas and positions were comparatively scarce for candidates fresh from internships who wished to qualify. It was an open question as to who would assume responsibility for specialty training, medical schools, hospitals or individual accredited board members.

Immediately, after World War II, however, there has been a great increase in the demand for specialty training and an increase in the number of available positions for training. The Navy Medical department has seen fit to offer specialty training to junior officers. The teaching hospitals have increased their number of residencies. The Veterans Hospitals have changed their organization to replace full time physicians with returned junior medical officers who wish to qualify as specialists before the American Boards. The summary of these dramatic changes is an increased demand for specialty training and an increased number of available positions for formal training acceptable to the American Boards. Exact figures are not yet available but there will be little disproportion between the number of graduates from medical schools and the number of specialty residencies offered. Within a few years this change in training will be productive of its effects upon medical practice.

Already, in the larger population centers, particularly those where medical schools are in existence, the teaching hospitals have closed staffs. Members of such hospital staffs are limited to specialists qualified by the American Boards and closed to the general practitioner. Other hospitals of the larger cities are showing preference

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# State Department of Public Health

## INFECTIOUS DIARRHEA OF THE NEWBORN

HENRIETTA HERBOLSHEIMER, S.B., M.D.
Chief, Division of Maternal and Child Hygiene*

Recent newspaper accounts of the outbreak of infectious diarrhea among infants on the brideship "Zebulon B. Vance" as well as four sizeable epidemics in Illinois hospitals during the first five months of 1946 have aroused considerable public interest in this disease.[17] "Since investigation of the cause of 'cholera infantum' by Benjamin Rush, early in 19th Century the significance of infantile diarrhea, its classification, diagnosis and treatment have been ever present in the minds of pediatricians."[15] Public Health workers also have been deeply concerned about this condition ever since it was first recognized as a distinct clinical entity.[4]

This disease which is also known as "epidemic diarrhea of the newborn is an acute communicable diarrheal disorder of unknown etiology affecting newborn infants in lying-in institutions within the first few weeks of life. It shows a marked infectivity, spreads rapidly from baby to baby and is characterized by a high death rate."[9]

As early as 1896, Booker of The Johns Hopkins University made an extensive bacteriological study of summer diarrhea of infants. He as well as Metchnikoff (at a later date) found they could incriminate no one pathogenic organism, but directed attention to the Streptococcus and Proteus vulgaris as specific incitants. These organisms survive as saprophytes in the alimentary canal of adults but are pathogenic to young infants. It was the conclusion of the early Johns Hopkins' workers that Proteus vulgaris and B. morgagni may grow better on inflamed intestinal mucosa.[16]

Another significant study on the etiology of this disease was the exhaustive investigation by George and Gladys Dick in relation to the epidemic at the Evanston Cradle in 1927. These investigators found B. morgagni as the possible pathogen known to all cases. This organism or the filtrate thereof injected intravenously into rabbits caused enteritis and death. Since this classic study of almost 20 years ago there have been numerous other studies in this country and abroad.[21]

There has been no agreement as to the etiological agent.[2] Competent workers have made many bacteriologic studies on secretions and body discharges of sick infants, contact cases, maternity patients, nurses, physicians, attendents in addition to similar studies on formulas, all supplementary feedings, and artificial and breast nipples. Results of blood agglutination tests during the disease and after recovery have been varied and inconclusive. Although it is not practicable in the course of this article to exhaust the literature on possible etiological agents, the following are some of the known and suspected organisms believed at one time or another to be pathogenic in neonatal diarrhea:

Streptococcus[19]
Proteus vulgaris[19]
B. morgagni[6&7]
Shigellae[20]
Samonellae[20]
Escherichia coli

*The Illinois Department of Public Health, Roland R. Cross, M.D., Director.

Staphylococcus aureus[5&8]
Streptococcus faecalis
Pseudomonas seruginosa[20]
B. Subtilis[13]
Suspected virus[14]

There is no universal agreement on the classical picture in all epidemics. The variation in part may be attributed to the stage of the disease in which the individual cases have been observed. The one factor which is common is the diarrhea, which in most instances is the overt phenomenon immediately preceding exodus.

*Incubation period*: The incubation period is commonly 5 to 7 days although variations from 4 to 27 days have been reported from various sources.

*Symptoms of invasion*: The onset may be insidious or explosive or change during the course of the epidemic. The symptoms vary with different epidemics: some epidemics are very mild and others are associated with high case fatality. In a number of epidemics few entirely breast fed infants have been reported as being affected by this infectious disease: the premature infant and those infants fed entirely on formulas seem most susceptible. The early signs of the disease as reported in the literature and as experienced in the Illinois outbreaks are (1) lack of appetite, (2) drowsiness, (3) listlessness, (4) failure to gain or weight loss, (5) feeble cry, (6) occasional vomiting, (7) distention, (8) change in character and frequency of stools with 5 to 8 loose or watery bowel movements per day[1] and (9) sore buttocks. Any initial unexplained weight loss is a very important early clinical finding.

*Differential diagnosis*: The following should be considered in a differential diagnosis: (1) improperly adjusted formula (2) indirect effect of cathartics given the mother (3) "prandial diarrhea" of some breast fed infants (4) "physiologic initial diarrhea of the newborn"[9] occurring during the second week of life when frequent loose stools with curds are seen (5) parenteral diarrhea, which may be differentiated by its acute onset with a high temperature (6) bacillary dysentery and salmonellosis, which are associated with high initial temperatures, bloody mucoid stools, and positive cultures and agglutinations.

*Toxic stage*: A large percentage of these cases rapidly present the picture of an intensely dehydrated toxic infant in shock. Stools are acid, watery, and may vary from yellow to green to brown; the finding of blood and mucus is rare. The weight loss is progressive and marked, the infant presents evidence of acidosis (low carbon dioxide combining power), drowsiness, coma, vaso-motor collapse and death. Hyperpyrexia is not a common finding of this disease except terminally but most infants manifest mild temperature elevation (99° to 100° Fahrenheit).

*Complications*: Otitis media, pharyngitis and broncho-pneumonia.

In a report of a study of a recent epidemic of diarrhea of the newborn at Temple University Medical School[10] the authors call attention to the biphasic course of this disease with pseudo-improvement followed by rapid collapse. This finding is likely to be a critical complication in the course of the disease of infants who are sent home during the stage of pseudo-improvement only to go rapidly down hill under the untrained observation of the usual attendants in the home.

*Recovery*: Favorable outcome might occur in from 3 to 26 days depending upon the character of the epidemic and the promptness in diagnosing the condition. The median rate of recovery in several of the reported epidemics is 14 days.

*Deaths*: As the newborn infant, especially the premature infant, has a poor antibody response, and unstable control of body fluids and electrolyte balance, death is a common sequel to this infection. The day of the disease at which death occurs varies considerably from epidemic to epidemic with figures ranging from 1 to 25 days after onset of the disease.

*Morbidity rate*: The morbidity rate varies from a very low figure in some epidemics to 100% of all cases exposed in other epidemics.

*Case fatality rate*: This figure varies from 20 to 60% depending upon the nature of the epidemic, the promptness of diagnosis. The type of therapy *may* influence the rate.

*Treatment*: Although a number of therapeutic agents have been used to combat this disease, there has been no marked superiority of any one drug. Sulfathiazole,[3,12] sulfaguanidine,[18] sulfasuxidine, sulfapyridine, sulfadiazine, Amigen, pectins, and opiates singly or in combination are used in conjunction with parenteral fluids (especially those containing sodium lactates and the potassium ion), plasma or whole

blood transfusions, protein milk formulas, vitamin K and gamma-globulin.

*Pathology*: Common pathological findings include: (1) congestive changes in the gastro-intestinal tract (2) congestive changes in the brain (3) superficial necrosis of the bowel[5] (4) inflammatory gastro-enteritis (5) acute hemorrhagic splenitis (6) involvement of Payer's patches and the mesenteric lymph nodes. In general, gastro-intestinal findings are surprisingly less in many cases, than would be expected from the clinical picture.

*Contributing factors to origination and spread of infectious diarrhea of the newborn*: It is the opinion of most workers that the following factors have a bearing upon the appearance and spread of this disease: (1) The increasing number of deliveries in hospitals where facilities are not adequate to cope with the increased number of mothers and infants. (2) Plumbing facilities in the nursery not adequate to encourage hand washing between the handling of babies. (3) No examining room for physicians in conjunction with the nursery. The ideal examining room for pediatricians should be connected with the nursery by a sliding window partition or dutch door arrangement, and should provide hand washing facilities for the physician as well as cap, gown, and mask and sterilized stethoscope and other necessary examining needs or therapeutic equipment. (4) Common hand towels for the nurses in nurseries. (5) Inability to maintain the recommended ratio of 1 graduate nurse to every 8 newborn infants. Under current nursing arrangements, a single registered nurse may be responsible for 20 to 30 newborn infants. (6) Keeping in an open newborn nursery, premature, diseased and malformed infants as well as boarding babies. (7) The transportation of infants through open corridors to the mother's room. (8) Failure in limiting visiting in the obstetric department. (9) Inappreciation of the constant threat of this disease occurring even in the best of well run nurseries.

*Prevention and control of infectious diarrhea of the newborn*: Prevention and control are dependent upon the following: (1) Nursery technic to include a cubicle for every infant, complete with supplies, clean gowns for the nurse, formula preparation supervised carefully, improved general cleanliness of the nursery, and no visitors or visiting physicians permitted to enter the nursery.[11] (2) Immediate isolation of suspect-cases. (3) Early institution of treatment. (4) Prompt reporting to the Local Health Officer. (5) Follow-up on all infants discharged from the hospital just before the epidemic in order to institute early care should these infants have been in the incubation stage at the time of their discharge from the hospital. (6) Questioning of patients and hospital personnel for history of previous illnesses (this questioning should include physicians also). (7) Epidemiological investigation. (8) Closure of the contaminated obstetric department in the presence of two or more cases at one time. (9) Renovation of complete obstetric department. (10) Reopening of a closed obstetric department contingent upon inspection and recommendation by the Illinois Department of Public Health.

*Summary*: The public health significance of infectious diarrhea of the newborn is reflected in infant mortality rates. Although there has been a progressive decline in death rates of babies during the first year of life, there has not been a comparable decline in death rates during the first month of life. A considerable part of this persistent lag in the reduction of neonatal mortality rates is due to conditions such as congenital malformation, birth injury and marked prematurity. Yet the role played by infections peculiar to the newborn in contributing to these high neonatal mortality rates has not been sufficiently stressed. When the trend of deaths from diarrheal infections among infants from one month to one year is considered, a constant decline is seen. In contrast, however, a persistently upward trend is evidenced in the death rates from diarrheal disorders in the neonatal group of infants. This increase is believed to be due in great measure to the prevalance of the syndrome epidemic diarrhea of the newborn.

Due to the inaccuracy of reporting, it is difficult to formulate a reliable impression of the incidence of this disease in Illinois or in the country as a whole. During the years 1941 to June 1946 in Illinois there have been 14 reported epidemics. We have reason to believe that there were additional outbreaks unrecorded. From a cursory study of the death certificates on neonatal infants during the first five months of 1946 we find that there were in Illinois 47 deaths attributable to infectious diarrhea of the newborn. There is no knowledge of the exact number of

cases but it is entirely reasonable to estimate that the cases involved totalled probably five times the number of deaths.

The lack of a uniform definition of diarrhea and the fear of stigma on the part of physicians and institutions have probably contributed considerably toward the paucity of reports of cases received in Health Departments. "The insidious onset of the outbreak is often determined in retrospect."[10] Upon the shoulders of the attending physician and the nursery supervisor lies the responsibility of vigilance, immediate isolation and prompt reporting of all suspected and actual cases of infectious diarrhea of the newborn, to the end that unnecessary deaths may be prevented and that our maternity hospitals which have rendered such splendid service to mothers and infants may be spared the costly and inconvenient procedure of closure and complete renovation of the obstetric department. This is a large responsibility in which the Illinois Department of Public Health assumes a share by offering aid to the institutions in establishing good facilities and technics for prevention of epidemic diarrhea at the onset of the condition. Furthermore, the Department of Public Health through the Division of Laboratories has the scientific means to carry on complete bacteriological and virological study of the individual cases immediately as they occur. Prompt reporting may be anticipated to start a chain of reactions including the adoption of isolation nursing technics, immediate application of therapeutic measures and the instigation of scientific study of this ever present threat to the practice of neonatal pediatrics in institutions.

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## AGREEMENT SIGNED WITH VETERANS ADMINISTRATION

The agreement between the Veterans Administration and the Illinois State Medical Society to provide care for veterans with service-connected disabilities at home by the physician of choice, has been signed, and became effective as of June 7, 1946. R. C. Kidd, Director, Supply Service, Veterans Administration, signed for the Veterans Service, and Dr. R. S. Berghoff, President, Dr. Walter Stevenson, Chairman of the Council, and Dr. Harold M. Camp, Secretary, signed for the Society.

Copies of the agreement and fee schedule are being mailed out from the secretary's office to all members of the society. As details of the program are developed, articles will appear in the Illinois Medical Journal.

# House of Delegates

HOUSE OF DELEGATES
ILLINOIS STATE MEDICAL SOCIETY
MAY 14, 1946
Chicago, Ill.

The first meeting of the House of Delegates of the Illinois State Medical Society was held in the Palmer House, Chicago, on Tuesday, May 14, 1946.

The meeting was called to order at 3:25 P.M. by the President, Dr. Everett P. Coleman, Canton.

THE PRESIDENT: I declare the 106th annual session of the Illinois State Medical Society in session. The first order of business will be the roll call of the Council and officers.

(The Secretary called the roll)

The next order of business will be the report of the Credentials Committee.

DR. E. S. HAMILTON, Kankakee: The Credentials Committee has certified 132 delegates, 48 from Chicago Medical Society, 65 from downstate, and 19 members of the Council and officers. I move that these delegates constitute the official body for this meeting of the House of Delegates. (Motion seconded by Dr. J. J. Moore, Chicago, and carried).

THE PRESIDENT: The next order of business will be the roll call by the Secretary.

THE SECRETARY: I would like to suggest that the attendance slips constitute the roll call.

DR. R. H. HAYES, Chicago: I so move. (Motion seconded by Dr. R. K. Packard, Chicago, and carried).

THE PRESIDENT: The next order of business is the approval of the minutes of the 1944 annual meeting.

DR. P. E. HOPKINS, Chicago: I move that the 1944 minutes be approved as published in the July and August issues of the Illinois Medical Journal. (Motion seconded by Dr. C. H. Phifer, Chicago, and carried).

THE PRESIDENT: The next order of business is the approval of the minutes of the special meeting of the House of Delegates held January 6, 1946.

DR. ROBERT H. HAYES, Chicago: I move that the minutes of the special meeting held January 6, 1946, be approved as published in the April, 1946, issue of the Illinois Medical Journal. (Motion seconded by Dr. L. O. Frech, Decatur, and carried).

THE PRESIDENT: The next order of business is the appointment of the following Reference Committees:

*Credentials Committee*: Drs. E. S. Hamilton, Warren Furey, W. E. Kittler, and Fred Muller.

*Committee on Attendance*: Drs. W. S. Bougher, J. K. Rosson, Bernard Klein, and Maurice Hoeltgen.

*Committee on Reports of Officers*: This committee will receive, review and report on reports of the President, President-elect, Secretary-treasurer, and Chairman of the Council. Drs. Robert H. Hayes, Chairman, E. E. Davis, and Richard Greening.

*Committee on Reports of Councilors*: This committee will receive, review, and report on reports of councilors and councilors-at-large. Drs. A. H. Bitter, Chairman, H. K. Scatliff, and G. E. Kirby.

*Committee on Reports of Standing Committees*: This committee will receive, review and report on reports of Committee on Professional Demeanor, Committee on Medical Education and Hospitals, Committee on Medical Benevolence, and Committee on Archives, and Committee on Medical Service and Public Relations. Drs. Darwin B. Pond, Chairman, T. A. Lawler, and Wade Harker.

*Committee on Reports of Council Committees*: Sub-Committee "A". This committee will receive, review and report on reports of the Educational Committee, Scientific Service Committee, Post-Graduate Committee, Medical Economics and Fifty Year Club Committee. Drs. H. A. Felts, Chairman, I. S. Trostler, and K. B. Rieger.

*Committee on Reports of Council Committees*: Sub-Committee "B". This committe will receive, review and report on the report of the Advisory Committee on Medical Care for Public Assistance Recipients. Drs. G. Henry Mundt, Chairman, Charles Allison, and J. J. Moore.

*Committee on Reports of Council Committees*: Sub-Committee "C". This committee will receive, review and report on the report of the Committee to Study Prepayment Plans for Medical and Surgical Care. Drs. C. H. Hulick, Chairman, James H. Hutton and C. O. Lane.

*Committee on Reports of Council Committees*: Sub-Committee "D". This committee will receive, review and report on the reports of Committee on Rural Medical Service, Industrial Health, Ethical Relations, Maternal Welfare and Veterans' Service Committees. Drs. Carl Steinhoff, Chairman, D. B. Freeman and A. C. Taylor.

*Committee on Reports of Council Committees*: Sub-Committee "E". This committee will receive, review and report on the reports of the Cancer Control, Tuberculosis, Venereal Disease Control, Inter-professional Relations, War Participation and Constitution and By-Laws Committee. Drs. J. S. Templeton, Chairman, W. O. Thompson and F. M. Hagens.

*Committee to Receive and Report on Reports of Editor, Committee on Scientific Work, and the President of the Women's Auxiliary.* Drs. John P. O'Neil, Chairman, J. C. Redington and Charles Papik.

*Committee on Miscellaneous Business*: This committee will receive and report on other matters of business as referred by the President. Drs. C. Paul White, Chairman, Eugene McEnery, and Lee O. Frech.

*Committee on Resolutions*: Drs. Mather Pfeiffenberger, Chairman, G. E. Johnson and Frank Deneen.

THE PRESIDENT: The next order of business will be the presentation of the annual reports. These have been printed in the handbook but they can be supplemented if desired.

## REPORT OF THE PRESIDENT

To the Members of The House of Delegates:

One year ago I sent to our Secretary my report of the past year's activities. At that time we were still at war; but as the end of hostilities was in sight we all hoped that the annual meeting could be held in the late summer or early fall. Refusal by the Office of Defense Transportation, and later by the inability to obtain adequate hotel and meeting accommodations, made it necessary for the officers of the past year to carry on to the best of their ability until this meeting could be held.

The House of Delegates was called together in January of this year to consider the proposed Prepayment Insurance Plan submitted by the committee; and also, to give approval to the suggestions of the Veterans' Administration that the service-connected disabilities of returned veterans be treated, at least in part, by the doctor of the veteran's choice. Approval of both items gave proper authority for your Society to start work on these plans. Both of them being important innovations which will effect definite changes in medical practice. We are in the midst of great changes and powerful forces are at work to completely revolutionize our American Way of Life, including the practice of medicine. Changes will inevitably occur, but if organized medicine can guide them and keep them under medical control, it will be possible to safe-guard the interests of both the public and the profession. These two procedures, that is the Prepayment Medical Care Plan, and the acceptance by the medical profession of the Veterans' Administration Plan, are, I believe, important steps in this direction.

The war has terminated successfully, and while at this moment Russia appears as a threat on the horizon, the probabilities of another war seem quite remote. Russia's action will perhaps force a continuation of the draft and will compel most of our recent graduates in medicine to serve a period of military service. Nevertheless, the majority of our medical officers have been discharged and the remainder will surely be out of service by July. This means the restoration of normal medical service to communities which have sometimes been quite lacking in it. It is a source of supreme satisfaction to all of us that the returned doctors are, in the great majority of instances, finding no real trouble in obtaining a location; and that they seem to have no difficulty in making a successful start in practice. This was the case after World War No. I and history seems to repeat itself in this respect. One complication has occurred which has as yet not been solved to any degree of satisfaction. A great many of the returning medical veterans are seeking post-graduate work. Routine courses in post-graduate study have been made available to a great number of these men and Chicago has been a pioneer in this work. However, there are others who are anxious to fulfill the requirements of the American Boards for specialization and these men are seeking places for Residencies, for which purpose the supply does not by any means equal the demand. The medical profession and the government owe these men a definite service and an opportunity to continue their studies towards specialization. As yet no definite means have been found where all those who want to take up a Residency in the various specialties can be taken care of at the same time. Further efforts should be made along this line to accredit institutions where good work is being done, but which have not previously been teaching institutions, so that they can take over part of the responsibility, and give these younger men the benefit of the excellent work being done in these institutions.

The Illinois State Medical Society is continuing to grow and each year its membership reaches a new high. Its problems are becoming more complex each year, and in fact, during the past two years they seemed to me to become more complex each month. During this two year period when so many of our more active men were both overworked, and past the period when over-exertion and long hours can be endured, it was difficult to get enough men to do the necessary work of the Society. Enough men were available but it was impossible to get them to contribute of their time. In consequence it became necessary to call again and again upon the relatively small number who were willing to be imposed upon and they have responded excellently. They have enabled your committees to accomplish a great amount of work and have kept your Society in a state of continued progress. Now that the younger men have returned it is to be hoped that they will accept these responsibilities and obligations and carry on the same work with increased energy and broadened vision.

THE COUNCIL: Under the leadership of Dr. Percy Hopkins the Council has met on the average of once a month. Its function is to supervise the activities of the committees by which the work of the Society is carried on. Regular meetings and usually a full attendance have enabled this to be done satisfactorily. It is a hard working group of men and to them is due the credit for the results obtained during the past year. The annual reports of the various councilors will more than bear out this statement.

THE SECRETARY: While the Council carries the responsibility and makes decisions as to policy during the year, the routine work of an organization the size of ours has to be carried on daily, and a responsible guiding hand has to be at the wheel the year around. Dr. Harold M. Camp has filled this post with his accustomed energy and ability. The secretary's office and the affairs of the Society run smoothly almost entirely because of his uncanny knowledge and ability. His background of experience is one of the Society's greatest assets, and we are fortunate to be able to have the benefit of his knowledge. Due to his experience, he has close contacts with the American Medical Association and numerous state organizations. He has represented the Society at hearings in Washington and has been able to safeguard the interests of a great many of our members during the war. Without him, many of our activities which seem to be almost automatic, would be accomplished with great difficulty, if at all.

THE DEPARTMENT OF PUBLIC HEALTH: Under the guidance of Dr. Roland Cross the relations of the State Society and the Department of Public Health have continued on a very friendly and cooperative basis. The increased interest of the public in public health measures, is being reflected in the activities of this Department. The work done, in Venereal Disease Clinics, Crippled Children's Clinics, etc., as well as in the County Health Units where they have been used, is largely under the supervision and in cooperation with the local medical societies. This makes for a better understanding as well as increased efficiency in public health work. As long as this spirit of cooperation continues we will continue to improve health conditions within the State.

THE JOURNAL: Our State Journal has also grown. Our editor working with the Adivsory Board and its advertising committee has steadily improved both the scientific papers and the type of advertising. When one compares it with any state journal from any other part of the country, it makes him proud of his local product. It is now more than self-supporting and has an increasing number of readers in other states.

THE EDUCATIONAL COMMITTEE: Miss McArthur and her staff constitute another group that functions throughout the year. They have given us an excellent type of publicity in the columns of a considerable number of newspapers throughout the state; and also have, through Miss McArthur's efforts, kept us in friendly relationships with many other organizations such as Women's Clubs, Parent Teacher Associations, etc. Contacts of this type help to keep us on good terms with these worthy and influential organizations at a time when their friendship is of vital importance. Along this line, I would like to call your attention to the report of the Committee on Cancer Control which is an example of the excellent work done by our members in a field which will perhaps, even this year, be receiving legislative attention and any action by state or federal bodies will need to be supervised and aided by this committee.

THE COMMITTE ON MEDICAL SERVICE AND PUBLIC RELATIONS: This is an old committee under a new name. It is attempting to cooperate between the State Society and the A. M. A. Committee of the same name. It is particularly interested in matters of health legislation and of improving the relationship between the medical profession and the public.

In the first aspect, there is decided interest in reference to the proposed legislation which has been introduced at Springfield by the Progressive Miners' Association, which would assess a gross income tax against every employed person and a similar amount from the employer, to be used to care for medical and hospital services. Some of the major objections to State Medicine are eliminated in the bill as proposed, but many states have had similar entering wedges introduced as companion measures to the Wagner Act.

The second aspect of this committee, that of improved relations with the public, is correlated to Miss McArthur's committee, but in line with the tendency in other state societies, has employed a Public Relations Counsel. This is partly an experimental move but it is based upon sound policy and is an accepted procedure in some other states. It is hoped that by the end of another year, definite progress will have been noted. This committee also had the responsibility of working with the various farmers' organizations, but did not have the time to give this important contact proper attention. So, recently this work has been delegated to a new committee under the Chairmanship of Dr. Harlan English of Danville. This is an active committee and I believe you will hear more from them in the very near future.

At a recent meeting, sponsored by the A. M. A., members of farm organizations were invited to present their medical problems. Many of them had complaints and criticisms which were largely well-founded but which were put forth on a basis of friendly and constructive criticism. They also heard a report from a member of the U. S. P. H. S. which quoted the usual unreliable and warped statistics from the Social Security Bureau which indicated that passage of the Wagner Act would flood the rural areas with doctors. It was so obviously a bit of campaign oratory that it did not seem to be as trustingly received by these practical farmers as the authors probably hoped. This type of propaganda indicates it is highly important that closer contact be made between the medical profession and the farmers for our mutual protection.

THE COMMITTEE ON THE CARE OF PUBLIC ASSISTANCE RECIPIENTS: This group, one of the most active committees, has met regularly during the past year. It has accomplished a great deal of

good but has not been able to obtain the same results in Cook County that it has downstate. Its primary function is to work with the state committee of the Illinois Public Aid Commission in an advisory capacity and as such has been able to safeguard the interests of the public and the profession in a rather efficient manner. Its chief accomplishment in my opinion has been the establishment of Medical Advisory Committees in many counties over the state. Where these committees exist, the profession has obtained local leadership in almost all health matters, and it has been shown that the public is anxious to accept proper medical leadership in such cases. In communities where these conditions do not exist, conditions are sometimes such that much improvement could be made. Such an Advisory Committee is able to work with other groups along medical lines and accomplish much for the profession. In my opinion these committees should become an important part of every County Medical Society and should receive unqualified support from the societies. This state committee is the chief protection the old age pensioner and the medical profession have against federal intervention in the care of the unfortunate and which intervention is often untimely and ill-advised. The committee should be instructed to continue to the best of its ability to further correct abuses and to try to give Cook County recipients the same type of care rendered down state.

THE COMMITTEE ON PREPAYMENT MEDICAL INSURANCE: This group has met a great many times, often once a week, for the past two years. After interviewing representatives from many groups, it was decided to recommend to the House of Delegates that the Society endorse a Prepayment Medical Care Plan, on the indemnity basis, which could be sold by private companies: this policy to include medical as well as surgical care; and to apply to the office and home as well as to care in the hospital. The recommendation was passed by the House of Delegates and at the present moment the policy recommended is waiting approval by the State Insurance Department. By the time this meeting is held, it is to be hoped that this policy will have received the support of a majority of the County Societies, and that it will already have been put into use throughout the state. It too is an experiment, and may have to be changed in one or several respects, but it represents at present our best safeguard against government interference, and if properly utilized will be an effective answer to the proponents of the Wagner Act.

THE WAGNER-MURRAY-DINGELL BILL: is our present menace, especially since it has been endorsed by President Truman. It is now getting ready for Senate hearings and will perhaps still be in committee while this meeting is being held. We have had information that persons in the Social Security Department have become expert in altering government statistics for devious purposes, and that the proponent of this bill will make statements to the effect that this country ranks very low from both morbidity and mortality statistics. It is hoped that the representatives we send from this group, will be able to present facts and figures to disprove the statements that the proponents have already been giving the press. The American Medical Association will be represented at these hearings, and we trust representatives of every State Medical Society. Only in this way can we have hope of defeating the bill in committee and thus avoiding a long and difficult battle on the floor of the Senate. At this writing, it is reported in the press, that Senator Murray, Chairman of the Committee, is permitting many organizations in favor of this bill to be heard. It is also stated that organizations such as State Medical Societies cannot be given time and opportunity for a hearing. Should this be the plan, no doubt the A. M. A. will be heard, but will have a preliminary build-up of animosity directed against it by the government planners, so as to try to counteract any evidence it may have. The State Societies should and are, making every effort, through their elected representatives, to be heard individually on this important bill.

During the past year your Society has worked on a high plane of efficiency. It has held fixed expenses down to a minimum, but in spite of the fact that the Journal has had an increase in income, the time is rapidly approaching when we as an organization will be compelled to increase our expenses. A great deal of the work in opposing the Wagner Act is expensive, and we cannot always depend upon such voluntary agencies as the National Physicians' Committee. The American Medical Association is increasing its activities but rather late. We may be compelled to continue our recent innovation of a Public Relations Counsel, and we may be required to assume additional expenses at any time and on short notice, in respect to self-protection in the national legislative field. On this account, an increase in dues should be considered by this Society. California has recently raised their dues to $100.00 per year; Michigan gets $35.00 plus assessments, and other states are taking similar action. Incidentally, last year California spent over $150,000 on Public Relations alone, which they were compelled to do because of adverse legislative threats. We may soon be faced with similar problems, and I feel that this group should give serious thought to an increase in dues as the most effective way of giving the Society financial stability for use in times of medical crisis.

Your Society has had to sail through many troubled waters during the past two years. The work has been both stimulating and arduous. It has called for innumerable committee meetings and for many appearances before other organizations. As your President, it has always been my policy to do all within my power to make friends for organized medicine, and to give other organizations our viewpoint. Every effort has been made to commit as few errors of policy as humanly possible, and in spite of all problems, complex or simple, to put forth the facts which organized medicine has to present, in as militant a manner as possible.

Respectfully submitted,

E. P. COLEMAN, M.D.
*President.*

## REPORT OF THE PRESIDENT-ELECT

To the Members of the House of Delegates:

The past year has written into history the termination of the most devastating war the world has ever witnessed, but peace has come at last, to the victor and vanquished. With the peace have come new problems and again to both the conquerors and the conquered. To those who lost, came misery, suffering, privation, short-lived, we hope, with our help. To us who won, came unrest, strife between labor and industry—the natural aftermath of any war which again we trust will be of short duration.

But there came to us—as citizens of the greatest country in all this world, a social and economic upheaval which constitutes a challenge to our American Way of Life. A "paternalistic" or bureaucratic attitude of the government towards its component states, counties, cities, towns and hamlets, involving all trades and professions not only *including* but *beginning* with ours, is widespread and growing prodigiously, and will if not checked, change the entire complexion of the practice of medicine.

It behooves us, therefore, at this auspicious time—assembled as we are in annual session, to pause and reflect, and take inventory of what this war has brought to us,—the medical profession—and prepare ourselves to meet the challenge.

Let us consider in brief detail what peace we have so gloriously won brings us and in the same breath demands of us—for mark you, we are not entitled to the rich gifts of peace—no matter how dearly it was purchased, unless we are prepared to use it wisely.

Focusing this discussion upon our own—the medical profession—what has peace brought us? Foremost of all, it has brought back to us—most of the gallant forty-five thousand members of our profession—who left everything, home, fireside, families, to don uniforms and scatter all over the globe to fight for the country they love, not to give battle with arms but with the special life-saving knowledge they had accumulated over years and years of experience. They gave it freely and so successfully,—that our army was provided with the lowest death rate and higheset recovery rate in the history of all the armies of the world throughout all times. To those who did not return, we pause and shed, shamelessly, a tear of anguish and regret. To that gallant crew who *did* return—we say in one breath —"Thank you, Pal, for doing what some of us were too old to do—and now that you are back home with us, we expect you to accept active, virile leadership in your profession and its complexities—and never have we needed you more."

As you so well know, while you were gone, the legislators, Murray, Wagner and Dingell, formulated a piece of legislation which would in brief, place the entire direction of the practice of medicine throughout the length and breadth of this land, so far as it affects the masses, in the custody of the federal government and under the directive of the Surgeon General. Whatever, if anything can be said for this proposed system, it amounts in its final analysis, to an utter and complete change from the practice you left and loved. I shall not go into detail concerning the demerits of this proposed pernicious experiment. However, when the President of the United States recently endorsed this proposal, then as your President-Elect, I wrote an editorial entitled "We Carried the Torch," copies of which were sent to United States Senators, Congressmen and the President of the United States. I should like to quote the closing paragraph of that editorial and leave it with you not only as a "thought" but as an invitation for your help in our common problem. "And now we the Oldsters of the medical profession of these United States, make this homely plea, 'Mr. President of the United States, Mr. Senator and Mr. Representative, if you please:

"We the old members of the medical profession of the grandest country in all the world, we who have carried the torch these past four years since Pearl Harbor, we beg of you, do not legislate our forty-five thousand 'Youngsters' who are still on the battle fields, out of the type of practice of medicine they left and loved. Wait—until they come home to discuss this with you. In the meantime if our plan of voluntary prepayment seems to you learned gentlemen inadequate, if it does not reach quite all of our citizens, then subsidize that minor percentage. The cost would be so small compared to what we have become accustomed, and wait please, until we, your medical profession, are once again a united 130,000 strong, so that we 'Oldsters' may in truth be able to strut, grin, hold up our chins and as we clasp the hands of our Youngsters be able to say, 'We Carried the Torch'."

Members of the House of Delegates, peace brought us—1. Our own beloved members back again—and 2, it brought us the Murray-Wagner-Dingell Bill. Are we doing anything constructively to offset what we are agreed is nefarious? Yes, of course! The committee under the able chairmanship of Dr. Charles H. Phifer has not only perfected a Plan of Prepayment of Medical Services but has received your official acceptance of this Plan. It should be in operation very shortly and will be reported to you by the chairman of that committee.

As President-Elect of your Society, this past year has been an interesting and a strenuous one. It has been my pleasure and my privilege to attend all but one Council meeting and the executive committee meetings which precede the Council meetings. The serious efficiency of both these bodies has deeply impressed me. The affairs of your Society are in able hands!

As President-Elect I have attended many and sundry meetings, both professional and lay. As pointed out last year by our President, Dr. Everett Coleman, the lay public is growing increasingly more interested in health and looks to us for guidance. We have a fertile field there for sincere and honest opposition to proposed pernicious federal legislation.

And so, Members of the House of Delegates, we come to a new year, a year fraught with tremendous possibilities and responsibilities for you and for me. But we shall not shirk them nor fear them.

Working harmoniously and as one body, with a common objective and with our glorious heritage of

two thousand years to inspire us, let us gird for the battle, and continue to give to the citizenry of the grandest country in the world the utmost and ultimate in medical service.

Respectfully submitted,

ROBERT S. BERGHOFF, M.D.,
*President-Elect.*

## REPORT OF THE SECRETARY AND TREASURER

To the Members of the House of Delegates:

It is most pleasant indeed to be able to submit an annual report at an annual meeting without the clouds of war hovering over us, as has been the case since the 1941 meeting. Many of you will well recall that a considerable amount of time on the part of this House of Delegates at recent meetings has been devoted to the consideration of many problems directly connected with the war. We had to annul all plans for a meeting last year at the order of the O. D. T., and for the first time since 1863, and the Civil War, no annual meeting was held. Physicians in the war which ended a short time ago made medical history, and the statistics which have been developed during and following the war show that our service men received the best medical care ever given to those participating in a major conflict.

Illinois made a notable contribution to the government with approximately 4,500 of its physicians with the armed forces. Fortunately the major portion of these men are now back either in practice or receiving additional refresher work before starting or resuming their professional work. Many of our physicians received one or more citations, and as would be expected quite a number made the supreme sacrifice, as did many others of our native sons.

The Procurement and Assignment Service for Physicians was notified early this year that after February 15, they would not be expected to recommend the release of medical officers, as these men would be gradually released in accordance with attained age, length of service and accumulation of service points. There was an exception made, however, in the case of certain types of specialists who were held as essential to the government regardless of points and age, as they were critically needed by the Army and Navy for the present. Throughout the war when matters arose requiring deliberate study and final decisions it was the policy in this state to hold a meeting of the entire state committee, and after a thorough consideration of the case at hand, the decision was made by the committee rather than by the chairman and vice-chairman for Illinois. This plan was heartily commended by the Central Office, as it was their policy likewise to have the entire Directing Board in session to consider many problems which were constantly arising.

Thus for the first time in the history of war in the United States, the important function of giving consideration to medical problems was delegated to the medical profession, and a committee composed of physicians only was allowed to consider the status of those under consideration for medical commissions. At this time the major portion of the duties of the Procurement and Assignment Service in Illinois is to give aid to returning medical officers seeking suitable locations, aid in finding a suitable place for residencies, refresher work under the "G.I. Bill of Rights," and furnishing much information which may be needed at the moment by these men.

Cooperating with the A. M. A. Bureau of Information, complete records of medical conditions and facilities in every community of the state were kept up to date and proved most useful in aiding hundreds of physicians asking for assistance. These files will be retained, and will be of much value to the Society in years to come. Likewise for the first time this Society was able to develop a complete file of all Illinois physicians, regardless of membership status, while previously the files were concerned only with actual membership of the Society.

### THE SOCIETY

Our numerous committees have functioned well indeed during the war, and their duties during the past year have been unusually heavy, requiring frequent meetings, and much work to be done. Several new committees have been appointed during the past year for specific purposes, and it is quite probable that this House of Delegates will be asked to appoint additional committees as has been requested in recent weeks.

One of the busiest committees during the past year has been the Committee to Study Voluntary Prepayment Medical Care Plans, appointed by the Council following the approval of a resolution by the House of Delegates at the last, 1944, annual meeting of the House. Beginning with an exhaustive study of all prepayment care plans in existence in this country, conferences were held with literally dozens of groups to get all possible information on that subject. The committee was not prejudiced at the beginning or during the study, as it was the desire of the entire personnel to get information, study existing plans, lay down basic factors, which in their judgment should be incorporated in any plan contract to be recommended, then spend more time endeavoring to find the best answer. It was noted that in most of these plans operating in various parts of the country, the benefits were limited principally to surgery and obstetrics in the hospital, with no provisions for care in the home or office, and only in a few cases was medical care of any type included.

With the continuous threats in Washington to develop a compulsory health insurance program for the entire country, it seemed imperative if a voluntary plan for providing medical care was to be set up in this state, efforts should be made to include the maximum amount of benefits, at the lowest possible cost, if we hoped to offer constructive substitutes for the proposed compulsory plan. When the committee approved its recommendation to the Council, and submitted it for Council consideration, an indemnity plan was considered the best for the beneficiaries. The Council in an all day session heard the presentations of the committee, and approved the recommendation that an in-

demnity plan be set up, and that they find a thoroughly reliably insurance carrier willing to write a policy that would give the benefits desired, at the rates recommended by the committee. One reliable Illinois insurance company was willing to accept this responsibility.

The Council, although delegated the power by the House of Delegates to approve a suitable plan and place it in operation, thought in all fairness to the membership of this Society as a whole, it would be preferable to call a special meeting of the House of Delegates, place the complete story before them, and let the House make the final decision. This was arranged, and the meeting was held in Chicago on January 6, 1946. In order to give the salient facts concerning both service and indemnity plans, one of the outstanding proponents of service plans, a man acting as director of such a plan over a period of several years, was an invited guest, and asked to give his own evaluation of the subject in controversy and answer questions that might be asked by members present. This gentleman, a physician, gave his story, and could only recommend a service plan, and thought anything else would not be acceptable. Many questions were asked and he gave the answers. When the final vote was called for, the recommendations of the committee as approved by the Council were adopted by a vote of more than six to one. More information concerning this important problem will appear in this handbook under the report of the Chairman of the Committee.

## THE MEMBERSHIP

During the past year there has been a marked increase in the membership of this Society, the roll at this time containing more than 9,200 members. There has been a very large increase in the Chicago Medical Society membership, as well as similar increase in the membership of most of the county societies outside of the county of Cook. Hundreds of former service men not previously members of this Society joined a component Society soon after resuming practice. There remain a considerable number of prospective members in various parts of the state, and it is hoped that the Society membership will increase steadily each year. Every medical society today should have on its membership roll the name of every physician who has the required qualifications.

## WAGNER-MURRAY-DINGELL BILL

As most of you no doubt know, Senators Wagner, Murray and Congressman Dingell last October submitted their latest version of the Wagner-Murray-Dingell Bill, this having been prepared and timed for introduction immediately after the President made his appeal to Congress for the immediate development of a compulsory health insurance program. In this bill, as in previous editions, the Surgeon General of the U. S. Public Health Service would be at the head of the plan, subject in many respects, however, to the will of the Social Security Board and its Director.

In contrast with previous bills, this bill was approximately 100 pages shorter than the former ones, and there were no provisions for the financial arrangement to be made to pay the costs of operating the plan after the end of the first fiscal year. No provisions were made as to the method of payment of physicians for services, and many other things, it was intimated, would have to be arranged later. The bill was promptly assigned to the Committee on Education and Labor, and it was stated that hearings would be held at an early date. Hearings on the Wagner-Murray-Dingell Bill began on April 2, and are still in progress. Those of you who have read the abstracts of the hearings will note that during the first two weeks at least, only those favoring the bill were heard.

When the hearing date was announced, this Society, along with many other similar state societies, wired Senator Murray as chairman of the committee to conduct the hearings, asking for permission to have a representative present to give the ideas of the physicians of Illinois concerning the bill. After some little time had elapsed, we were informed that with the extensive agenda which had been prepared, they would be unable to permit individual State Medical Societies to have representatives appear before the committee, but they would permit a representative of the A. M. A. to appear, and the date set tentatively for the appearance of this representative was April 17. We were informed, however, that if we desired it, we could prepare a short brief on the subject giving our views, which should be sent to the committee, and this would be considered by the Committee and published in the proceedings at a later date. For your information, such a protest was sent to Senator Murray.

Statistical data were presented by several proponents of the bill, which although very similar and undoubtedly received from the same source, are at considerable variance with those which we receive at frequent intervals. In quoting statistics from various countries relative to mortality and morbidity, no reference has been given as to the standards which are used in these countries respectively, nor those used in our own country, and an investigation will show that there is a marked difference, and erroneous impressions are easily developed when the standards are not reported.

We in this country remain firm in the belief that where personal initiative prevails, where medicine is on a competitive basis and operates as a private enterprise, a better type of medical care invariably results than when medical care is subsidized and operates from a central office many miles from the majority of the practitioners of medicine who give actual care. We are thoroughly convinced that medical advances, research developments, everything connected with the effort to further reduce the mortality and morbidity, are more successful under the American System than would be possible if everyone in medicine, dentistry, nursing and hospital management was directly under governmental supervision in their many activities.

## THE COUNCIL

During the past year, it has been necessary to hold frequent meetings of the Council, this being due in large measure to the fact that we were not permitted to hold an annual meeting during 1945, and also because so many important matters constantly came up

which demanded early consideration. Council meetings have always been well attended, and absences on the part of individual members were always due to unavoidable circumstances.

Those desiring additional information concerning the activities will no doubt be greatly interested in the report of the Chairman of the Council, which appears in this handbook. It is necessary for some members of the Council to spend two nights on a train and one full day in Chicago in order that they may be present at any of these meetings, and it is a great sacrifice on their part to fulfill their prescribed duties as members of an important body in our Society set-up.

## DEATHS OF PROMINENT MEMBERS

During the past fiscal year there were 129 deaths of members reported to the secretary's office. In view of the fact that too frequently many deaths are not reported for several months, this is not an accurate figure and does not give the actual facts.

Carl E. Black of Jacksonville, for many years active in the affairs of this Society, died at Jacksonville while attending a conference on medical matters in a local hotel, January 13, 1946. He was born at Winchester, Illinois, July 4, 1862. His father, Dr. G. V. Black, became known throughout the world as the father of modern dentistry, and was the first Dean of the Northwestern University Dental School, which position was likewise held by another son, Dr. Arthur Black, likewise a member of this Society, who died only a few years ago.

Doctor Black ranked high among Illinois surgeons for many years, and took great delight in relating the number of major operations he performed after passing his eightieth birthday. While practicing for some 58 years in Jacksonville, Doctor Black was first a member of the Council, being one of those who organized the Council at the time the Constitution and By-Laws were completely revised in 1902-03. He served as president of the Illinois State Medical Society in 1904, and for many years thereafter was a regular attendant at the annual meetings. In addition to being the author of several books, Doctor Black had a hobby—that of collecting and mounting photographs of physicians, and his collection was probably the largest owned by a single collector at the time of his death.

A few years ago Doctor Black came before the House of Delegates at the annual meeting and offered this collection to the Illinois State Medical Society, to be housed permanently in the building of the Illinois State Historical Society in Springfield, the collection to be held there as "The Carl Black—Illinois State Medical Society Collection." This generous offer was accepted, and as secretary of the Committee on Archives, Doctor Black and his committee solicited many hundreds of additional photographs, which he mounted and added to the collection. The entire collection is now safely stored in Springfield, and it is the intention of the Society through the Committee on Archives, to add each year to this valuable collection of photographs. The thousands of friends of Doctor Black in Illinois and all over the nation will long remember this grand man of medicine, and will cherish his memory for many years to come.

Another past president of this Society passed away since the major portion of this annual report was written. James Fulton Percy, president of the Illinois State Medical Society, died in Los Angeles on Friday, April 26 at the age of 82. Doctor Percy was graduated from Bellevue Hospital Medical College, New York, in 1886, and for many years was an outstanding surgeon at Galesburg. He offered his services to the government when World War I broke out, served during the war, and after separated from service, moved to Los Angeles, where he has remained in practice until recently.

Doctor Percy, like Doctor Black, was a member of the first Council established when the Constitution and By-Laws were completely rewritten in 1902-03, served in that capacity until elected president-elect, then for years following his term as president accepted many responsibilities delegated to him by the Society. For years he was interested in the surgical treatment of cancer, and some 35 years ago developed his water cooled speculum for using his cautery in treatment of malignancies in the female pelvis. He became quite active in the work of the California Medical Association, appearing as chairman of committees, and receiving a number of important assignments, never letting his interests in organized medicine wane until he became totally incapacitated. Although he has not attended one of our annual meetings in a considerable number of years, he has retained his interest throughout the years, frequently writing Doctor Black, as an intimate friend for more than a half century, as well as officers of the Society asking for information on the activities of this Society, and frequently adding some of his own suggestions which he thought would be of general interest.

Frank X. Walls, for years Professor of Pediatrics at Northwestern University Medical School, died January 14, 1946. He was a graduate of Northwestern in the famous class of 1891, and many members of this Society have his name on their diplomas, and will long remember him as an instructor back in college days.

Peter Bassoe, for many years an outstanding practitioner, as well as instructor in neuropsychiatry, died in Chicago on November 5, 1945.

Isaac D. Rawlings, for a number of years Director of the Illinois Department of Public Health, and later attached to the Chicago Health Department, died on October 21, 1945.

Charles J. Drueck, an outstanding proctologist, as well as teacher for many years, died in Chicago, June 30, 1945. Doctor Drueck wrote many scientific articles for publications in many journals over a period of years, and many of you will recall the considerable number of these articles which have appeared in the Illinois Medical Journal in recent years.

Sumner Miller, Peoria, for many years head of the Peoria Health Department, died December 15, 1945. Doctor Miller became quite prominent among health officers, and carried out his many duties efficiently dur-

ing his long term of office. He participated quite actively in the affairs of this Society, and was especially active in the Section on Public Health and Hygiene.

Fauntleroy Flinn of Decatur, for years an outstanding specialist in the field of radiology, died July 26, 1945. He was very active in the work of the Section on Radiology until compelled to retire on account of illness.

Charles Morgan McKenna, Professor of Urology at the University of Illinois College of Medicine, died May 13, 1945. He was ever interested in the affairs of this Society, and appeared before many county medical societies throughout the state, as well as on the program at the post graduate meetings, many times in recent years.

Charles F. Read, a prominent neuropsychiatrist, and for a number of years superintendent of the Elgin State Hospital, died suddenly one month ago. He too was always interested in medical society affairs, and was an active participant in many of its activities. He was one of those instrumental in the development of the Physicians' Association, Department of Public Welfare, which group has conducted its annual session on Tuesday morning, during the annual meetings of this Society.

Many former officers of their respective county medical societies passed on to their Eternal Reward during the past year. Among these, Harry F. Bennett, Litchfield, long active in the affairs of his county, and this State Society. Gerald McShane, Spring Valley, acted as secretary of the Bureau County Medical Society for several years, while maintaining a large practice. During the war he was on the staff of the Green River Ordnance Plant near Dixon, endeavoring to do his bit in the war effort, in addition to caring for an extensive practice. He died December 18, 1945.

Others interested in the work of their medical societies over a long period of time were W. A. Hancock, Fairfield, who died January 16; A. R. Lyles, Virginia, whose death occurred December 18; and J. V. Ferrell, Eldorado, who died May 8, 1945. Other prominent men who have died during the past fiscal year are William Crowley, Chicago; Walter H. Allyn, Waverly; Edwin H. Bradley, Peoria; Matt Bloomfield, Joliet; Albert H. Andrews, Chicago; Thomas J. Williams, Evanston; Arthur C. Kleutgen, Chicago; Henry A. Aschauer, and A. I. Hagler, Springfield. Time will not permit us to add to this already extensive list, but once more death has taken its toll from our membership, striking harder perhaps, on account of the long hours these men have worked during war time with less time off than they should have had.

We who remain to carry the torch during the coming year will long remember these men who have made the Supreme Sacrifice, and endeavor in every way possible to do our work so that we too may be highly regarded by our associates in years to come.

In closing this annual report, your Secretary once more desires to publicly express his appreciation for the encouragement and assistance he has received from members of the Council, officers of the Society, and the county society secretaries, who have cooperated splendidly under the most trying times any of us have ever experienced. It is only through such cooperation that it is possible to carry on with so many of our fellow practitioners away and serving with the armed forces.

## MEMBERSHIP DATA

| | | |
|---|---|---|
| Members in good standing as of April 30, 1945 | | 8,865 |
| Added during the year: | | |
| New members | 555 | |
| Reinstatements | 58 | |
| Total added | | 613 |
| | | 9,478 |
| Dropped during the year: | | |
| Died | 129 | |
| Moved away | 45 | |
| Resigned and Withdrawn | 4 | |
| Dropped for Non-payment of Dues | 80 | |
| Duplicates in file | 3 | |
| Total dropped | | 261 |
| Net Total, April 30, 1946 | | 9,217 |

## FINANCIAL REPORT OF THE SECRETARY

### Receipts from County Societies

| | | | |
|---|---|---|---|
| Adams | $ 384.00 | Henry | 274.00 |
| Alexander | 104.00 | Iroquois | 144.00 |
| Bond | 96.00 | Jackson | 112.00 |
| Boone | 128.00 | Jasper | 32.00 |
| Bureau | 128.00 | Jefferson-Hamilton | 208.00 |
| Carroll | 112.00 | Jersey | 0.00 |
| Cass | 48.00 | JoDaviess | 80.00 |
| Champaign | 710.00 | Johnson | 0.00 |
| Chicago Medical Society | 33,210.00 | Kane | 1,256.00 |
| Christian | 328.00 | Kankakee | 560.00 |
| Clark | 80.00 | Knox | 480.00 |
| Clay | 80.00 | Lake | 728.00 |
| Clinton | 108.00 | LaSalle | 656.00 |
| Coles-Cumberland | 0.00 | Lawrence | 152.00 |
| Crawford | 216.00 | Lee | 224.00 |
| DeKalb | 16.00 | Livingston | 296.00 |
| DeWitt | 152.00 | Logan | 176.00 |
| Douglas | 168.00 | McDonough | 192.00 |
| DuPage | 496.00 | McHenry | 232.00 |
| Edgar | 240.00 | McLean | 576.00 |
| Edwards | 32.00 | Macon | 710.00 |
| Effingham | 0.00 | Macoupin | 0.00 |
| Fayette | 80.00 | Madison | 568.00 |
| Ford | 136.00 | Marion | 288.00 |
| Franklin | 56.00 | Mason | 112.00 |
| Fulton | 192.00 | Massac | 56.00 |
| Gallatin | 80.00 | Menard | 56.00 |
| Greene | 96.00 | Mercer | 72.00 |
| Hancock | 112.00 | Monroe | 64.00 |
| Hardin | 0.00 | Montgomery | 160.00 |
| Henderson | 32.00 | Morgan | 176.00 |
| | | Moultrie | 32.00 |

| | | | |
|---|---|---|---|
| Ogle | 136.00 | Shelby | 88.00 |
| Peoria | 1,910.00 | Stephenson | 512.00 |
| Perry | 128.00 | Tazewell | 152.00 |
| Piatt | 72.00 | Union | 124.00 |
| Pike | 88.00 | Vermilion | 1,086.00 |
| Pope | 16.00 | Wabash | 80.00 |
| Pulaski | 40.00 | Warren | 160.00 |
| Randolph | 126.00 | Washington | 64.00 |
| Richland | 72.00 | Wayne | 86.00 |
| Rock Island | 608.00 | White | 24.00 |
| St. Clair | 208.00 | Whiteside | 304.00 |
| Saline | 128.00 | Will-Grundy | 774.00 |
| Sangamon | 1,076.00 | Williamson | 368.00 |
| Schuyler | 58.00 | Winnebago | 1,072.00 |
| | | Woodford | 104.00 |

Total ..... $55,956.00

### Receipts and Payments
May 1, 1945 to April 30, 1946

#### Receipts

| | |
|---|---|
| Component Societies | $ 55,956.00 |
| Subscriptions—Journal | 312.35 |
| Advertising—Journal | 51,444.23 |
| Exhibits—State Meeting (1945 Meetings) | 242.50 |
| Exhibits—State Meeting (1946 Meeting) | 6,705.00 |
| Interest—Bonds | 2,531.25 |
| Dividends (C. & N. W. Ry. Co.) | 93.00 |
| Bonds Called | 5,000.00 |
| Bonds Called—Premiums | 250.00 |
| Miscellaneous and Refunds | 112.78 |
| Total Receipts | $122,647.11 |
| Cash Balance, May 1, 1945 | 75,575.59 |
| Total | $198,222.70 |

#### Payments

| | |
|---|---|
| Secretary's Office Expense | $ 14,481.43 |
| Council Expense | 6,377.40 |
| Educational and Scientific Service Committee Expense | 11,169.47 |
| A. M. A. Meeting Expense | 577.86 |
| State Meeting Expense | 938.27 |
| State Meeting Refunds to Exhibitors (No meeting 1945) | 3,917.50 |
| Maternal Welfare Committee Expense | 621.66 |
| Post Graduate Committee Expense | 554.89 |
| Legal and General Counsel Expense | 850.00 |
| Medical Service and Public Relations Committee | 9,955.98 |
| Advisory Committee on Medical Care for Public Assistance Recipients Expense | 470.25 |
| Procurement and Assignment Committtee Expense | 19.65 |
| Journal Expense | 38,306.04 |
| Committee to Investigate Prepayment Plans for Medical and Surgical Care Expense | 3,105.37 |
| Committee on Archives Expense | 320.00 |
| Committee on Medical Economics | 75.27 |
| Committee on Professional Demeanor Expense | 40.46 |
| Fifty Year Club | 87.05 |
| Unemployment Insurance Deposit | 90.99 |
| Transfer to Benevolence Fund | 13,000.00 |
| House of Delegates (January Meeting) | 425.66 |
| Total Payments | $105,385.20 |
| Cash Balance April 30, 1946 | 92,837.50 |
| Total | $198,222.70 |

Respectfully submitted,
HAROLD M. CAMP, M.D.,
*Secretary-Treasurer.*

FRED N. SETTERDAHL
Certified Public Accountant
224 Robinson Building
Rock Island, Illinois
May 2, 1946

To the Members of The House of Delegates:
Illinois State Medical Society

### CERTIFICATE OF AUDIT

I have audited the following accounts of your Society for the fiscal year ended April 30, 1946:

Secretary's Office—Dr. H. M. Camp;
Journal Office—Mr. L. E. Malley;
Educational Committee—Miss Jean McArthur, Secy.
Benevolence Fund—Dr. H. M. Camp

SECRETARY'S ACCOUNTS:

Receipts: Dues received from the Component Societies have been verified with duplicate receipts, the master ledger cards of each Component Society and compared with the Secretary's Report as published.

The Journal Receipts have been verified with reports from the Manager, etc. Other receipts consist of Exhibit rentals, Journal Subscrpitions, interest, etc.

Payments: Payments are made by check and are supported by approved vouchers, orders, invoices, etc.

There was no Annual Meeting in 1945; therefore, refunds were made to exhibitors for the state meeting amounting to $3,917.50, which is included in the payments.

All funds are deposited in the name of the Society and were reconciled with statements received from depository banks.

Bonds amounting to $90,000.00, par value, were examined. During the year bonds amounting to $5,000.00 were called. In addition to above bonds, the Society holds 31 and 70-100 shares of voting trust certificates for common stock, no par value, of the Chicago &

Northwestern Railway Company which were issued in lieu of bonds formerly held. Bonds called are included in the cash receipts.

During the year there has been transferred to the Benevolence Fund a total of $13,000.00, which is included in the payments.

The accounts of the various departments have been well kept, and, in my opinion, represent the true transactions for the year. The Council will be furnished with a detailed audit report.

Respectfully submitted,
FRED N. SETTERDAHL,
*Certified Public Accountant*

THE SECRETARY: In the handbook we refer to the present status of the care of veterans with service connected disabilities. You will recall at the special meeting of the House of Delegates held January 6, 1946, we presented the Illinois plan and the fee schedule which had been drawn up, a copy of which was handed to each member of the House. Each man was asked to look it over and report to our Committee relative to any changes which he thought should be made. We were authorized to send the fee schedule to various types of specialists, which was done. Our Committee met and went over all the reports that came in, all the letters relative to changes, and presented the revised schedule to the Veterans' Administration. We were notified that our fee schedule was satisfactory. Our plan was like the first plan which was approved for the state of Kansas. In view of the fact that the Veterans' Administration had six veterans, they asked us to wait until the Kansas plan or eight different plans in force as to actual care of had been operating a few weeks before they would give final approval to our plan. The Kansas plan has been operating only two or three weeks. I saw a report recently stating that General Hawley had visited the state of Kansas and was greatly in accord with their plan. I, therefore, think our plan will be approved in a short time.

Only a few weeks ago we received a letter from the Federal Security Agency stating that all records for procurement and assignment were to be retained in the office of the Illinois State Medical Society. That pertains to the records of the counties outside of Cook and also to Cook County, and gives us a complete record of every physician who holds a license to practice medicine in the state of Illinois as of March 1, 1946. That gives us very valuable information. Tomorrow, May 15, the work of the Procurement and Assignment Service in Illinois ceases. In many states the offices were closed on February 15, but they held us for two months in view of the fact that we had so many returning men who wanted help. We were requested to use the facilities of the Illinois State Medical Society to aid returning physicians in getting suitable locations.

I want to say a word about the membership which has increased since this group met in last regular session. We now have 9,217 members and since the report was printed we have had a dozen or two additions reported from several counties. It is impossible to say what the actual membership is as of today.

## REPORT OF THE CHAIRMAN OF THE COUNCIL

To the Members of the House of Delegates:

The Council of the Illinois State Medical Society has met regularly since the last report submitted to the Delegates in May, 1945. A report of the activities of the Council was sent to each delegate by mail although it was not possible to arrange a meeting of the House of Delegates in 1945. The report for the period from May, 1944, until 1945 as printed is also available for consideration. In compliance with the Constitution and By-Laws of the Illinois State Medical Society, the Councilors and other officers of the Society have remained in office because of the failure of successors to be elected.

Several attempts were made to arrange meetings of the House of Delegates during the period dating from May, 1945, through the Fall of 1945, but such restrictions were still imposed as to make impossible even a one day streamline meeting. The Delegates are familiar with the fact that a special meeting of the House of Delegates was called in January, 1946, for the purpose of considering the prepayment plan for medical care and also the consideration of a Society program to be submitted to the Veterans' Administration, having to do with the care of veterans by private physicians. Although the House of Delegates authorized the Council to proceed in the matter of initiating the prepayment plan for medical care in Illinois, the Committee, as well as the Council, felt that the matter was of sufficiently serious importance to justify the call for a special meeting of the House of Delegates. At this meeting of the House of Delegates the recommendation of the Committee for the adoption of the proposed plan was carried by a vote of 64 to 10. It is necessary that physicians throughout the State cooperate if this plan is to accomplish the purpose for which it was intended. Meetings have been or will be held throughout the State at which an opportunity will be given the physicians to become familiar with the plan.

The Journal Committee has had meetings with the Editor, the Editorial Board and the Business Manager of the Journal and the quality and make-up of the Journal are worthy of earnest consideration. The financial status continues good in spite of increased costs for paper and labor. Labor difficulties, such as scarcity of help particularly, have been the cause of delays in dates of publication of some of the numbers but progress is being made in remedying this difficulty. A section on Industrial Health edited by Dr. Joseph Chivers has been added and has provided a source of much favorable comment. About 10,000 copies of the Illinois Medical Journal are published monthly.

The Council in its advisory capacity to the State Committee on Procurement and Assignment has been

confronted with few problems this past year other than serious attempts to encourage further the separation of doctors in service. Definite action was taken to inform the military personnel that the Illinois State Medical Society was urgently requesting the release of men in service who are no longer needed.

The Advisory Committee to the Illinois Public Aid Commission has met regularly throughout the past year with the members of the Commission and at the date of writing this report no further progress has been made towards solving some of the problems still existing in Cook County that remain unsatisfactory.

Four post-graduate meetings have been held throughout the State during the year. This number it is planned will be increased to ten such meetings this year. These meetings are always very well attended, are very informative and of little expense to the Society. An attempt has been made to provide topics that will be of greatest interest to the men recently returned from service.

The Committee on Medical Service and Public Relations has been active throughout the year and saw fit during the year to sponsor an Enabling Act in the State Legislature which was passed with little opposition. This Act allows for the setting up by County Societies or the State Society of non-profit prepayment plans for medical care. The Enabling Act stands ready to be used at any time the House of Delegates decides to take advantage of its existence. At present the prepayment plan for medical care, in operation in Illinois, approved by the House of Delegates at its special meeting in January, 1946, is not one to come under the Enabling Act. House Bill No. 250 which required physicians to give first aid in any emergency was passed by the Legislature and subsequently vetoed by the Governor. Governor Green by vetoing this bill and in his message to the Legislature accompanying his veto showed himself to be a staunch friend of the medical profession and he was informed that he was entitled to the gratitude of the doctors in Illinois for having affirmed his confidence in the integrity of the medical profession. The Executive Secretary of this Committee continues to devote a great part of his time to the welfare of the State Society, not only in regard to proposed legislation but in making many appearances before various groups in the interests of the medical profession and has been of tremendous value to the Council of the Illinois State Medical Society. The Council has seen fit recently to authorize the employment of a Public Relations Counsel. The Committee has given much time and thought to the recommendation of such a project and for some time has been convinced that the employment of such an individual or individuals could reap much benefit for the Society. It is hoped that the arrangement recently made with Salter & Associates may prove of tremendous value to the Society in counteracting and preventing much unfavorable criticism and exploitation of the medical profession. The possibility of creating a much more favorable attitude toward the medical profession on the part of the public seems very good. There are many methods apparently which may help to mold public opinion. This project is to be continued for a definite period of time at the end of which a further appraisal will be made and if at the end of this period the plan has manifested sufficient merit or value, it is hoped to continue it in force.

Doctor Roland R. Cross the Director of Public Health in Illinois continues as in the past to be most cooperative with the Council and the medical profession of the State of Illinois. He attends all Council meetings as well as numerous committee meetings and his advice is sought perhaps as often as he seeks advice from the Council. He is held in high esteem as Director of Public Health as well as a member of the Society.

The dues of men in service in the Army and Navy have again been remitted during the past year due to the failure of the House of Delegates to convene. Further consideration of this matter will devolve upon the House of Delegates. In connection with dues there has been established in some of the County medical societies residency membership consisting of men recently discharged from service. The House of Delegates may feel inclined to consider granting a concession in regard to the dues of these men who have been recently separated from service. These men should be given every encouragement to become a part of organized medicine.

The Committee to study prepayment medical plans has continued to meet regularly and often and is deserving of the commendation of the House of Delegates and the members of this Society for their untiring efforts in behalf of a legitimate, sensible plan for medical care that will provide adequate coverage for individuals subscribing to such a plan. The principles set forth by this Committee as being requisite before any insurance company can obtain approval of a contract, have been in no way contravened by the recent ten point program set up by the Council on Medical Service and Public Relations of the American Medical Association. It is further to be stated that any insurance company that agrees to adhere to these principles may receive the approval of this Committee and offer its contracts for sale.

A Special Committee was appointed of which Dr. Harlan English of Danville is Chairman to cooperate with the various farm groups in Illinois as well as with the American Medical Association Committee. The farm groups in Illinois are against compulsory insurance in any form and it is certain that our interests and objectives are mutual in this matter as well as their attitude toward the Hill-Burton Bill upon which hearings were recently held in Washington, D. C. It is felt that this Committee can accomplish much of mutual benefit to organized medicine and the farm groups by cooperating wholeheartedly.

The plan for the care of veterans by private physicians which also was adopted at the special meeting of the House of Delegates in January, 1946, has been submitted to the Veterans' Administration and while at the date of the writing of this report the plan has not yet been adopted by the Veterans' Administration,

a communication has been had from them which contains no unfavorable criticism of the plan but states that acceptance of the plan has been delayed depending on the experience gained in a nearby State upon whose plan the Illinois plan was patterned. The Council incidentally has seen fit to recommend adoption of a fee schedule submitted to the Veterans' Administration as the pattern for future dealings with any Federal or State group.

The Council saw fit at its July, 1945, meeting to approve the organization of a State Committee of the National Physicians' Committee for the extension of medical care which at that time had been approved by 21, and at present has the approval of more than 35 state medical societies. The State Committee was formed consisting of the Councilors and physicians of all of the County medical societies throughout the State. The Council on October 31, 1943, went on record as endorsing the "present activities of the N. P. C."

The Council has caused to be sent in the name of the Illinois State Medical Society, a telegram to Senator Murray, Chairman of the Committee on Labor & Education, and a sponsor of the Murray-Wagner-Dingell Bill, requesting an appointment to appear in opposition to the bill and give a specific reason for desiring to do so. Copies of this telegram were also sent to Senators Brooks and Lucas informing them that such application had been made. At the time of the writing of this report an opportunity to appear in opposition of this bill apparently will be denied all groups other than those which are national in organization but a canvass of the senators and congressmen will be continued.

The finances of the Illinois State Medical Society continue to remain in excellent condition as is testified to by the report of the Secretary-Treasurer, in spite of increasing expenses and the remittance of the dues of members in service. The membership as of April, 1946 in the Illinois State Medical Society was 9,203, the membership of the Chicago Medical Society constituting 5,574 of this number.

The Chairman of the Council, having served three continuous years in that capacity, desires to express his thanks and appreciation to the House of Delegates for having allowed him to serve in the Council and wishes to thank the Council for the privilege of causing him to preside and for being so tolerant as well as cooperative in conducting the business of the Council. He is also grateful to the many men who have served faithfully on the various committees which he has appointed and in whom no confidence has been misplaced. Some of the men on the various committees have given tremendously of their time and effort and are deserving of the gratitude and appreciation of the members of the Illinois State Medical Society. The Chairman wishes also to publicly thank Dr. Camp and his office force for their continued helpfulness and cooperation during the past year.

Respectfully submitted,
PERCY E. HOPKINS, M.D.,
*Chairman of The Council*

DR. HOPKINS: As is customary, the Council usually recommends to the House of Delegates a definite sum in regard to dues or per capita assessment. The Council recommends to the House of Delegates that the per capita assessment be fixed for the coming year at $10.00 for the year 1947.

The second item deals with the activities of the Society with regard to its efforts to combat the Murray-Wagner-Dingell bill. The Society has caused telegrams to be sent to Senators Murray, Brooks and Lucas during the past year requesting an appointment to appear in opposition to the bill. This statement is contained in the report of the Medical Service and Public Relations Committee, but it is mentioned here merely by way of supplementing the data contained in that report. As you have undoubtedly heard, this application was denied with the statement that testimony would be limited to organizations which are national in scope. The Society, therefore, even though we are not to be allowed to appear before the committee, has at least filed our opposition to the bill.

## REPORT OF THE COUNCILOR OF THE FIRST DISTRICT

To the Members of The House of Delegates:

The report of the Councilor of the First District is quite brief this year. Things have been going on about as usual and no major disturbance has arisen.

The most pleasing thing I can report is that about 98 per cent of the men who were in service of the country have returned and it is a real pleasure to again see them at the Staff meetings and at the regular county meetings.

Our district is functioning quite well and most of the societies are quite active.

There is considerable interest in the state program for medical care and I believe that such interest speaks well for the success of the program. Naturally there is also considerable interest and discussion of the Wagner Bill now in committee hearing.

Wherever I have heard the fee bill discussed for service connected disabilities of veterans, it has been quite favorably commented upon.

All told I believe our district is wide awake and I am glad to report same.

Respectfully submitted,
L. J. HUGHES, M.D.,
*Councilor First District*

## REPORT OF THE COUNCILOR OF THE SECOND DISTRICT

To the Members of The House of Delegates:

There are eight counties in the Second District, of which six have active societies. The other two counties are small and most of the physicians in them are members of the society of an adjoining county. In spite of the difficulties of another war year all the societies have made a creditable showing with regular meetings, good programs and good attendance. Now

that doctors are returning from military service there is already evidence of even greater interest and enthusiasm. The Postgraduate Conference which is being planned for this fall is looked forward to with great pleasure, especially by these returning service men.

The activities of the National Physicians' Committee and the voluntary health insurance program have been the subject of much discussion. However, it appears that both of these programs are getting increasing support. The plan for a county health department has met with considerable opposition in at least one county of the district.

As is no doubt true elsewhere, doctors returning from the service are having great difficulty in finding offices and places for themselves and their families to live. So far no solution of the problem has been found.

Respectfully submitted,
EDGAR C. COOK, M.D.,
*Councilor Second District*

## REPORT OF THE COUNCILORS OF THE THIRD DISTRICT

The Chicago Medical Society, the Medical Society of Cook County, seems to have entered a new era of growth and achievement. In numbers, it has passed 5,700 and it is only a question of time when every practicing physician in the County, who is eligible, will seek membership in the Society.

The reasons for this phenomenal growth of the past few years and the fact, more and more, the members of the eighteen specialty societies are becoming interested in the problems of the Parent Society. These problems are economic as well as scientific. The fact that we are now engaged in a gigantic struggle which will decide the question of who is to control and guide Medical practice, our Schools and Colleges, Medical men or Politicians, is no doubt uppermost in men's minds.

Medical education in Cook County, the past year, has maintained its accustomed high standards with our Medical Schools expanding and growing with the needs, not only of Chicago and Cook County, but of the entire middle west. Thus we read of great plans in progress at Northwestern as well as a great building program for Loyola. The other Medical Schools are, in every way, keeping step with those mentioned.

It is with regret that we note the resignation of Dean Raymond Allen from his duties at Illinois, to become President of Washington State University. It is also to be noted that Dean Roscoe Miller has returned from the wars to his work at Northwestern. These are only a few of the high-lights. The Central Society and its fifteen branches have held monthly scientific meetings which, with the nineteen specialty groups and their monthly meetings, make it possible for men in Cook County to spend almost every night in some form of post-graduate study.

Much could be said about the responsibility of the Chicago Medical Society with its great Medical Schools, its great Hospitals and its great teachers of Medicine in development of our City into the greatest Medical Center in the world. Everything is at hand, including the blessings of unbounded wealth of our great middle west. Only greater courage, wisdom and foresight are needed.

In October and November, 1945, the Institute of Medicine with the Chicago Bar Association sponsored a symposium on Medico-Legal problems. This series of meetings inspired much interest in the professional men of the City as well as the general public. The attendance was large and much favorable comment was noted in our press.

By action of the Council, a new Society membership has been designated, intended especially for men recently returned from the wars. Many of these young veterans are seeking residencies in our Hospitals and wish to continue their Society affiliation; therefore, an amendment to our Constitution and By-Laws was adopted which provides for the continuance of the Intern-membership with dues of two dollars per annum and a membership for residents with yearly dues of five dollars.

It has been suggested that perhaps the State Society might be disposed to forgo the collection from our County Society, the usual fee exacted from regular members, from this group, and thus encourage membership throughout all student years.

In 1945, we reported that a Committee of the Council was making a survey of the Tuberculosis problem. This Committee completed its assigned task and through it chairman, Dr. Berghoff, reported its findings to Governor Green. One result of this survey—a Tuberculosis Hospital building is now in progress.

The Public Relations Committee, following instruction from the Council, is now conducting a survey of the facilities in Cook County for the diagnosis and treatment of Cancer. This, when completed, should prove of great interest and value.

The second annual Clinical Conference, postponed from 1945, was held at the Palmer House from March 5th to 8th, 1946 under the Chairmanship of Robert Berghoff, there being four days of intensive postgraduate study. A most successful meeting, with Speakers and men registered for study from every part of the Nation. The registration was in excess of 4,200. The Scientific exhibits, under the direction of J. P. Simonds, were of the very highest quality while the technical exhibits, which bring to the Profession the latest in Surgical, Medical and Literary equipment, received the very highest comment by men in attendance.

In recent years, a great deal has been said about the need of a Permanent Home for the Society. A Committee, more or less active, has been studying the problem with little progress in evidence. The Committee is convinced that this need is genuine. In March, a check for one thousand dollars was received in the Society office from an anonymous donor, to be used for the securing of such a home. This, added to a previous small gift, marks the beginning of a fund set aside for this distinctive purpose.

This past year has seen a constructive program, both scientific and economic, carried forward most successfully. It is hoped and confidently expected that with the return of more than fifteen hundred of our young men from the wars, we will go on from year to year with vigor and energy to greater achievements than we ever before have known.

Respectfully submitted,
OSCAR HAWKINSON, M.D.,
*Councilor Third District*

## REPORT OF THE COUNCILOR OF THE FOURTH DISTRICT

To the Members of The House of Delegates:

The Fourth District has had a rather active year, interested in the economic factors of the profession as well as busy in the active practice of the profession.

All of the counties, excepting two, have held their regular meetings and have had programs which according to reports and observations have been very interesting to their members and have been attended by a percentage of the membership above the average for several years.

The two counties not holding meetings, are Stark and Henderson. Both of these counties have but few physicians within their limits. Stark County has for some time been affiliated for scientific purposes with Henry County and the arrangement is mutually very agreeable. Preparations are under way to consolidate Henderson with Warren and this will likely be accomplished soon.

May we call your attention, however, that whilst this arrangement works out very well for the individual physicians in the respective counties in most ways, yet there is the disadvantage that this arrangement lessens their representation in this House of Delegates, if they are combined into one component society by charter from the State Society.

It is very interesting to draw conclusions from the following statistics concerning the population of these ten counties and the facilities within their borders for the practice of the profession of medicine.

| *County* | *Population* | *Hosp. Beds* | *Physicians* | *Ratio of Pop. to Physicians* | *Ratio of Pop. to Hosp. Beds* |
|---|---|---|---|---|---|
| Fulton ..... | 60,000 | 122 | 31 | 1935 | 492 |
| Hancock ..... | 27,000 | 15 | 22 | 1228 | 1800 |
| Henderson ... | 7,600 | 0 | 4 | 1900 | 0 |
| Henry ..... | 43,800 | 150 | 38 | 1152 | 292 |
| Knox ..... | 52,200 | 240 | 42 | 1243 | 217 |
| McDonough .. | 26,900 | 145 | 34 | 791 | 188 |
| Mercer ..... | 16,000 | 0 | 12 | 1333 | 0 |
| Peoria ..... | 153,300 | 1107 | 190 | 806 | 138 |
| Rock Island .. | 113,300 | 518 | 97 | 1168 | 218 |
| Schuyler ..... | 13,500 | 15 | 6 | 2250 | 900 |
| Stark ..... | 8,000 | 0 | 7 | 1143 | 0 |
| Warren ..... | 21,200 | 72 | 21 | 1009 | 336 |
| Totals 10 Counties .. | 542,800 | 2338 | 604 | 898 | 232 |

This Fourth District has a population of 542,000, among whom there are 604 physicians represented by 13 delegates in this House of Delegates.

Many of our members who were in military service are now returned and generally have been able to find facilities for beginning their civilian practice without too much difficulty.

Two instances of potential trouble, between the component county society and insistent applicants for membership, have finally been ironed out to the satisfaction of both parties; and this was accomplished by the local societies and not by the Councilor.

It has been a great pleasure as Councilor to meet the members of the various societies of this Fourth District, and to be associated with the men on the Council.

Respectfully submitted,
CHARLES P. BLAIR, M.D.,
*Councilor Fourth District*

## REPORT OF THE COUNCILOR OF THE FIFTH DISTRICT

To the Members of The House of Delegates:

The past four years have been critical years for the medical profession. With the close of the war and the return of about one-third of the active physicians, conditions effecting the profession are rapidly returning to normal. Some of the smaller societies have not been active during the past year as it was difficult to get enough members together to hold a meeting. Now that a heavy load has been taken from the older men, meetings are being held on schedule and interest is shown in some of the recent problems pertaining to the profession.

Several of the counties have had discussions on the prepayment plan of medical care and are much interested in this program. The proposed plan has many advantages both for the patient and the attending physician. The committee appointed to study the plan and recommend some action has spent much time and effort in perfecting a definite plan and is deserving of a great deal of credit.

The organization of county health units is receiving considerable attention in the Fifth District. McLean County voted favorably on this question last June and will open a County Board of Health, July 1st. An outstanding public health official in the person of Dr. Earl E. Kleinschmidt, Mt. Pleasant, Michigan, has been chosen as the Medical Director. A tentative staff of sixteen persons has been provided and present indications are that this unit will be a real factor in improving health conditions in this county. No organized health work has been carried on in the rural areas and Bloomington has not employed a full time health officer. There is a real opportunity for a constructive health program in this county.

The membership in the various counties is about the highest it has ever been. The following deaths have occurred during the past year: Dr. T. L. Hutton, Hartsburg; Dr. F. C. McCormick, Normal; Dr. H. F.

Bennett, Litchfield; Dr. L. A. Balche, Pekin. Dr. Bennett had served for more than twenty-five years as secretary of the Montgomery County society.

The recent action of the Council in appointing a committee of downstate men to cooperate with the farm organizations is desirable. A local committee from every downstate society would be beneficial to the profession. The farm and home bureaus are well organized and offer opportunity for contacts which may be valuable to the profession.

Respectfully submitted,
RALPH P. PEAIRS, M.D.,
*Councilor Fifth District*

## REPORT OF THE COUNCILOR OF THE SIXTH DISTRICT

To the Members of The House of Delegates:

Your Councilor is happy to report that conditions in the Sixth District remain about as they were in the report which was given for the 1945 Meeting which was cancelled.

The Sixth District is happy also to report that most of those physicians who had been in the armed forces are now back home and, of course, every one is happy about that. There are a few isolated instances of men who still remain in the service but I think that can be explained by the fact that they were late getting in and, naturally, have not collected sufficient points for their discharge. Certainly it will not be too long before every one will be back except those men who have just gradnated and served their internships and these men are obligated to serve a certain number of months.

The Sixth District and the entire State Medical Society suffered a great loss in the passing of our friend, Dr. Carl Black, of Jacksonville. Dr. Black was a fine gentleman and of a kindly sympathetic nature. The interests of the profession were always uppermost in everything he did. His hobby was the collection of photographs of those physicians who had practiced and are now practicing in the State of Illinois. This collection has now been sent to the Historical Department of the Historical Division of the State of Illinois at Springfield. Our sympathies have been extended to the family of Dr. Carl Black.

Most of the visits I have made to the various County Societies in my District have concerned the economic side of the profession today. It has been my pleasure to explain to the various Societies what the Illinois State Medical Society is doing to combat the sinister legislation proposed in Washington. As a rule, the men are pretty well in favor of the State Society's approval of a prepaid medical indemnity insurance plan. I am quite sure that this District will give whole-hearted support to this program.

It has been a great pleasure to serve the Sixth District and also the profession of the entire State as a member of the Council and my association with those men on the Council has been most pleasant indeed.

Respectfully submitted,
WALTER STEVENSON, M.D.,
*Councilor Sixth District*

## REPORT OF THE COUNCILOR OF THE SEVENTH DISTRICT

To the Members of The House of Delegates:

This year your Councilor desires to change the usual order of reports to the House of Delegates. During the past year we have seen a magnificent triumph and a brilliant success in every theatre of war and we trust a lasting peace throughout the countries of the world. May God speed the homeward journey of all America's gallant forces which are still left on foreign soil. We are proud to claim brotherhood with every fighting man and woman whose individual efforts assured the victory that is ours today. Whether they fought with bayonets or scalpels, with gauze or guns, with bullets or brains, they fought the good fight—an important job well done. To those who have returned from the field of battle, we welcome you home again. To those who have made the supreme sacrifice—may they rest in Eternal Peace. To those who fought under the sign of Caduceus—highest commendation for medicine's momentous contribution to the victory. The road back from the four points of the compass and from the Seven Seas they have come—Medical Officers headed for their home-lands—duty done. This is but a milestone in the road leading from the battlefields of the past to the horizon of the future. Before July, 1946, some 40,000 former Medical Officers will have ended their journey and will be seeking homes, seeking offices, seeking in the postwar world for men and women inspired by the high ideals that swept the Armies of America to victory.

The ideology of the average returning Medical Officer has been admirably summarized by Captain Robert Monfort, AUS, an Airforce Surgeon in England. I quote: "And now at last we have the privilege of forgetting the past if we so choose and of looking forward to the future without fear. Our vote is still good, our lips are far from sealed, our interests in progessive government as well as progressive medicine may be quickened. The interlude of war may well have been the herald of new and deeper and more significant interest. Family, freedom, and satisfaction—these three representative treasures outmeasure every other yardstick of gain." May I also add that since Pearl Harbor, American Medical Officers' contribution to victory has been presented in a pageant of heroism and sacrifices uncqualed by members of any other profession. After the smoke of battle has drifted across the pages of history, we are left amazed that so few could have done so much in so short a time.

The inevitable readjustment period has uncovered many deplorable conditions whereby returning veterans are unable to take their place in civilian practice—lack of office space, rent gouging tactics, and the uncooperative attitude of some members of the profession. The unhappy plight of many is intensified by depleted bank accounts, lapsed insurance policies, and ill health which have drained thir resources and their stamina.

Professional *esprit de corps* will doubtless enlist the active cooperation of every physician who remained in

civilian practice during the war years. Doctors on the home front who effectively maintained the health and well being of the civilian population and made so many sacrifices in both time and energy will unquestionably be guided by the same high principles in aiding the re-orientation of professional colleagues.

It is imperative that the morale of former Medical Officers be maintained. Their return to civilian practice must be hastened by the active cooperation of every member of the medical profession, especially by those who are able to share their offices or make other positive contributions.

During the war years while the ranks of the American medical profession were temporarily depleted, politicians attempted and are continuing to undermine the structure of American Medicine. The returning Medical Officer is amazed to find that the proponents of Socialized Medicine plan to hamstring his future activities by regimentation of doctors and denial of the basic principles of freedom of action for which he fought.

Will the assured financial security of Political Medicine find willing advocates among the thousands of medical men who have been unable to rehabilitate themselves under the existing order, or leave the Officers to the inspiring environment of unfettered American lives? Unless the return of American Army and Naval Officers to private practice is hastened by the active cooperation of established confreres, the proponents of government controlled medical care may find the medical profession divided against itself. The future of medical practice in this country may hinge on this issue.

The majority of the American people have not yet chosen between government and privately sponsored medical care plans but the danger is eminent. A United Medical Profession is the ony answer to the revolutionary challenge of American Medicine. Three physicians out of every four are reported to be vigorously opposed to Socialized Medicine. It rests with this significant majority to bring pressure to bear on Congressmen and unless it is done immediately, it may be too late.

Respectfully submitted,
I. H. NEECE, M.D.,
*Councilor Seventh District*

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## REPORT OF THE COUNCILOR OF THE EIGHTH DISTRICT

To the Members of The House of Delegates:

We are now passing through a post-war period, following the most destructive war in world history. Business is trying to get back to peace time production; the different Allied Nations are endeavoring to agree upon plans for a permanent peace and the men in service are being discharged.

In order to get information about the doctors, I have sent a questionnaire to all the component medical societies in the Eighth District. The report is as follows:

| *Society* | *No. of Members* | *Members in World War II.* | *Members Returned* | *Deaths in Service* | *Other Deaths Members* | *50 Year Club* |
|---|---|---|---|---|---|---|
| Champaign | 99 | 32 | 25 | 1 | 2 | 5 |
| Clark | 10 | 3 | 2 | 0 | 0 | 2 |
| Coles-Cumberland | 36 | 5 | 3 | 0 | 2 | 2 |
| Crawford | 17 | 3 | 1 | 0 | 2 | 1 |
| Douglas | 21 | 6 | 5 | 0 | 1 | 0 |
| Edgar | No Report | | | | | |
| Jasper | 5 | 2 | 1 | 0 | 0 | 1 |
| Lawrence | 13 | 4 | 3 | 0 | 2 | 3 |
| Richland | 10 | 6 | 4 | 1 | 4 | 0 |
| Vermilion | 84 | 20 | 19 | 0 | 7 | 4 |
| Totals | 295 | 81 | 63 | 2 | 20 | 18 |

This report needs very little explanation; however, it gives evidence that the Eighth District was well represented in the armed forces in World War II. I regret to report that Dr. Tom L. Weber, Olney, and Dr. Gayle Laymon, St. Joseph, lost their lives in service. Those who have returned are very happy to resume their civilian practice and have been welcomed home by the members of their county medical societies. They are all opposed to federal control of the practice of medicine. All counties in the district are organized to help support the Prepayment Plan as suggested by the American Medical Association and the State Medical Society.

The following deaths occurred in this district in the past two years: Richland County—Doctors Daniel W. Bower, G. S. Trotter, Frank J. Weber, Sr., R. L. Williamson; Champaign County—Doctors H. L. Davison, G. F. Way; Vermilion County—Doctors A. J. Fletcher, G. A. Potter, L. L. Steiner, F. W. Barton, M. S. Fletcher, C. H. Evans, J. F. Gainer; Lawrence County—Doctors Victor Brian, R. R. Trueblood; Douglas County—Doctor O. F. Barnes; Crawford County—Doctor J. W. Carlisle; Coles-Cumberland County—Doctors Martin W. Bisson, Albert T. Summers; and Doctor McCord, Paris, Illinois.

I want to express my appreciation to the officers and members of the component societies of the Eighth District in keeping up their county organization. It has been a great pleasure to have served on the Council and to have had the opportunity of associating with such a fine group of men. I am very sorry that my health will not permit me to continue to be active in Organized Medicine.

Respectfully submitted,
C. E. WILKINSON, M.D.,
*Councilor Eighth District*

## REPORT OF THE COUNCILOR OF THE NINTH DISTRICT

To the Members of The House of Delegates:

The Ninth Councilor District is composed of 14 counties in the southeastern part of the State. The distance from the northern to the southern line of the district is 115 miles; east and west, 75 miles. Four counties in the district have good-sized memberships. They usually have monthly meetings with good scientific programs that are well attended. The smaller counties where there are limited memberships, have meetings only occasionally, but the members of those smaller counties usually attend meetings held in the adjacent county. Three of the small counties in the south end of the State have joint meetings. Aside from this, practically all the active physicians in southern Illinois are members of the Southern Illinois Medical Association that meets each November. The scientific programs at these meetings will compare favorably with that of the scientific programs in the State Society, and they are well attended.

The Southern Illinois Medical Association met in the Ninth District last year, and one of the refresher courses sponsored by the Illinois State Medical Society, was also held in the Ninth District last year. Both of these meetings were well attended.

Practically all of the physicians in the Ninth District who were physicially fit, served with the armed forces during the World War. Most of them have now been mustered out and many of them have returned to their former locations. So far as I have been able to learn, the only casualty among our medical men was Dr. Mosely, a young physician just out of school and not yet licensed in Illinois. He was inducted into the Naval Medical Corps and lost his life in the South Pacific.

Many of the old physicians, some who had retired, reopened their offices and cared for the ills of our people during the second World War. They did a splendid job.

The medical profession of the Ninth District is unalterably opposed to the Murray-Wagner-Dingell Bill, and have contacted their congressmen who have agreed to consult the wishes of the medical profession on all health legislation now pending before Congress.

Respectfully submitted,

ANDY HALL, M.D.,
*Councilor Ninth District*

## REPORT OF THE COUNCILOR OF THE TENTH DISTRICT

To the Members of The House of Delegates:

Welcome Home, veterans of the Tenth District, to our Medical Society!

Throughout the district, with the exception of a few societies, meetings have been few and far between. We have won the war, but it looks like we are losing the peace. In your homecoming you will find some things changed, which are principally due to our socialized political set-up.

I recommend that you all get together and inform your Congressmen what you would like for him to do and make it plenty strong. Congressmen as a whole like to brag what they want to do for the veteran; now put the bee on him. The Tenth District, I believe, has only one Congressman that might be a little obstreperous and difficult to handle due to his administration affiliation. I not only recommend this policy for the Tenth District, but for the state as a whole because, as you know, this is election year.

You will also find a great increase in the number of your patients carrying Blue Cross Hospital insurance and the hospitals so over-crowded that it is almost impossible to get beds for your patients. When you start to study the various types of medical care insurance that are coming into practice, you will probably be a little confused and dizzy trying to make your mind as to which is the best. The Council of the Illinois State Medical Society has gone on record endorsing the voluntary indemnity plan to be handled by a private insurance company, these companies to be checked and endorsed by a committee of the State Medical Society.

Just another reminder. Our State Legislature has passed a law making it compulsory for a physical examination of school children every five years (constitutionally questionable) and every County Medical Society will be called upon by the school authorities regarding this examination and cost for same. An appeal will be made for a cut rate on your regular examination charge. Be careful about your agreements as to the fee rate. It is just another social peg expecting you doctors to continue giving information for charity's sake.

We must salute our old-timers as we have three more eligible for membership in the Fifty-Year Club this year. They are Dr. G. R. Hayes, Marissa; Dr. Fred Rose, Millstadt and Dr. Herman Schmidt, Okawville. These country boys come from a hardy stock. More power to them!

Respectfully submitted,

G. C. OTRICH, M.D.,
*Councilor Tenth District.*

## REPORT OF THE COUNCILOR OF THE ELEVENTH DISTRICT

To the Members of the House of Delegates:

Interest in medical affairs has been greatly renewed by the return of medical men from the armed forces. Very properly the returned physicians have manifested a great interest in medical societies. Many of the officers at present are former members of the armed services. The return of these men has lessened to a considerable extent the work and responsibilities of those men who remained at home.

Your Councilor has attended all of the meetings of the Council of the Illinois Medical Society and in addition has done a large amount of Committee work,

particularly on the Committee on Medical Service and Public Relations, the Committee on Medical Care of Public Assistance Recipients, and a special Committee appointed to study the Prepayment Medical Care Plans. During the past year and a half he has attended at least two meetings of a committee each month in addition to his other duties. Your Councilor has attended meetings of most of the component County Societies and finds them in a flourishing condition. Regular monthly meetings are held in DuPage, Kankakee, and Iroquois Counties, and weekly meetings are held in Will-Grundy County. As in the past, Ford County meetings are held at irregular intervals due to the relatively small number of physicians in the county and the large distances they must travel. It is to be hoped that with the return of many younger men regular monthly meetings will be held in Ford County. Attendance at medical meetings during the current year has been greatly increased over the last two years and there is evidence of interest of the Medical Profession in the problems of Medicine.

Your Councilor particularly calls to your attention the importance of getting in operation the Prepayment Medical Care Plan which was approved by the House of Delegates at the special meeting held in Chicago in January. In his opinion, this is probably the last opportunity the Medical Profession will have to put in operation a voluntary plan and unless we take this opportunity before a compulsory National Health Plan is started by the United States Government, it seems inevitable that some compulsory form will be started. Your Councilor wishes to express his thanks to the officers of the various component societies for their support and cooperation in the past year. He asks them to continue their interest in the scientific and economic problems of medicine.

Respectfully submitted,
E. S. HAMILTON, M.D.,
*Councilor Eleventh District.*

## REPORTS OF COUNCILORS AT LARGE

To the Members of the House of Delegates:

I thought when I submitted my report last year to the House of Delegates that it would be my final report as Councilor-at-Large. The fact that the Office of Defense Transportation later cancelled all conventions in 1945 made it impossible for the Illinois State Medical Society to hold its annual meeting, thereby making it necessary for all officers to continue in office until it was possible to hold an annual meeting of the House of Delegates.

In the interim since my last report I have attended all meetings of the Council, the meeting of the House of Delegates of the American Medical Association, the special meeting of the House of Delegates of the Illinois State Medical Society, numerous meetings of local and national medical organizations where many subjects relating to the future of medicine were discussed. I have also served as Chairman of the Medical Advisory Committee to the Illinois Public Aid Commission, and Chairman of the Committee for the Study of Prepayment Plans for Medical, Surgical and Hospital Care of the Illinois State Medical Society.

The past year has been a period of many activities in medicine. The cessation of war has brought many physicians home. Many are looking for offices, others for locations, some, postgraduate work, others for short review courses, and still others, training as residents in the specialties. The profession is greatly agitated over the possibility of socialized medicine. Prepayment plans for hospital care have put on extensive campaigns for membership. Hospitals are crowded. Many of the returning physicians are looking for hospital privileges. Most state medical societies and many county organizations have developed prepayment plans for medical and surgical care. Medical meetings while curtailed for several years have again been reestablished. There is likewise much agitation over the future of medical education.

There has been a great amount of work accomplished within this state during the past two years that should be of material benefit in the medical care of the citizens of the state. The study of tuberculosis within the City of Chicago and later through the state under the chairmanship of President-Elect Dr. Robert S. Berghoff and co-chairman, Dr. James H. Hutton, led to an appropriation by the General Assembly of the State of Illinois for the building of tuberculosis sanitariums in different sections of the state. The survey of chronic illness which was undertaken by the Institute of Medicine of Chicago and the findings in reference to it and the lack of facilities for the care of these people, resulted in the General Assembly of the State of Illinois appointing a committee for the study of chronic illness among the indigents of the state. The passing of legislation requiring the licensing and regulation of nursing homes should be of material interest to every physician in the state; it should help provide standards of nursing care which, if carefully regulated, may help to release some hospital beds for acute illnesses.

The organization of the rural health units provides an important factor in the care of the people in those districts.

The activities of your State Council in helping to develop a program for the medical care of the veterans of Illinois has offered a most constructive aid in helping to provide medical care for the veterans in their respective communities. It offers a far superior type of care to what was given the veterans of the last war.

Much of the legislation before Congress as well as in the states at this time is of a social nature. The most of it will have a direct bearing on the practice of medicine in the future. It is interesting to note the opposition that arises among the public to the passage of the Murray-Wagner-Dingell bill. The new E. M. I. C. bill introduced by Senator Pepper is also a highly socialistic bill and should have constructive opposition.

There has been intense interest manifested throughout the nation by the citizens, physicians and colleges in reference to the question of future pre-medical and

medical education. In view of the prominent position that the State of Illinois occupies in this field, it seems constructive to make a few comments regarding the present status of medical education.

The regulations of Selective Service in reference to education and pre-medical training have been changed so frequently during the past four years that they are confusing to most people. In the early part of the war pre-medical training was restricted to eighteen months. Later it was limited to 4F's. More recently, 4F's are accepted in service.

The Office of War Mobilization and Reconversion in January, 1946, again refused to take any action to defer pre-medical students. This was based on the Army's rigid need for the replacement of men who have served for long periods overseas. The bulk of replacements for those men must in their opinion come from the eighteen year old group. The question of the extension of the draft has been before Congress for many months. It has many advocates as well as many opponents. The extension of it would no doubt seriously curtail the future of medical education. At the time this report is being completed the matter is still before Congress and it is hard to predict the outcome.

In the fall of 1945 there was a great deal of apprehension regarding the number of pre-medical students that would be available in September, 1946. It is now apparent that the returning veterans will furnish sufficient applicants to fill the freshman class of our medical institutions this fall. In some of the medical schools the freshman class has been completely filled. The majority of them are returning veterans. The age is about three or four years older than the applicants before the war. They have had more pre-medical training than students entering medicine during the war. The greater number of them have had three years of pre-medical work. It thus makes it possible for colleges to re-establish their pre-war scholastic requirements.

In the fall of 1945 the war had produced a scarcity of male pre-medical students to the degree that a large number of applicants admitted to the classes were females. The present status shows that we have just as many female applicants but preference is being given to returning veterans. This necessarily reduces the number of women who will enter the study of medicine this fall. It is possible that the returning veteran will continue to fill our classes for two or three years, by which time pre-medical training may be re-established on a pre-war basis.

The specialized training program of the military forces has been a matter of great concern to all students, interns, and hospitals as well as our medical staffs. It is interesting to note that the Navy discontinued its medical training program December 25, 1945. Students were discharged to the Reserve Corps subject to recall. All Army students in the specialized training program were discharged March 30, 1946, except the seniors who will stay in until they graduate and then receive their discharge. The entire accelerated program for medical training for the Army will be discontinued June 21, 1946.

In view of the many questions that arise regarding the effect of the G-I Bill of Rights on medical education, it seems only constructive to make a few comments in regard to it. The G-I Bill of Rights was effected by legislation passed by Congress just before the recess. Many of these changes are of particular interest to former medical officers. Most of the medical journals have carried statements in regard to this program. The requirement in the original law that a veteran over 25 years of age at the time of entering service should show that his education was interrupted in order to be entitled to educational benefits, was eliminated. It has been changed so that the time within which a course may be instituted was extended from two to four years, and the time during which education or training may be afforded was lengthened from seven to nine years after the termination of the war. The subsistence allowed for a veteran without dependents was increased from $60 to $65 a month, and for a veteran with dependents from $75 to $90. This was made effective as of June 24, 1944, the date of enactment of the original law. In view of this legislation many officers have taken advantage of the opportunity for additional training, some in short refresher courses, others in special training and residencies.

There is nationwide interest in prepayment plans for medical and surgical care. Most states have either instituted programs or are in the process of studying and developing a plan. Your state has been active as evidenced in the report of the Committee on the Study of Prepayment Plans for Medical and Surgical Care.

It has been a great pleasure to assist Dr. Everett P. Coleman, President; Dr. Robert S. Berghoff, President-Elect, and the members of the Council in the many problems that have come to the Council. The fact that the House of Delegates was unable to meet since 1944, except for the special session that was called in January, 1946, to consider prepayment plans, placed an additional burden upon the Council.

This report concludes my term as Councilor-at-Large. I have enjoyed the honor you have conferred upon me. It has been a great privilege to know the members of the Illinois State Medical Society and to serve with each of you in behalf of a great organization in American medicine.

Respectfully submitted,

CHARLES H. PHIFER, M.D.,
*Councilor-at-Large.*

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To the Members of the House of Delegates:

The year's work has been occupied with problems mainly concerned with returning veterans; first, getting them out of the service; second, locating them; third, finding office space for them; and fourth, finding homes for them to occupy.

The returning veterans have developed new ideas for the practice of medicine and on the whole are enthusiastic about the need for organized effort and cooperation in carrying out the relationship between the patient and physician.

There is need for a planning committee in each city

to develop plans and ideas that may be promulgated for the members of the local society. In larger cities this can be done by committees, but in smaller societies it can be done by the society on a whole. Probably the greatest good comes from the development of ideas and ideals from the broad base of our county medical societies from which by proper resolutions they are forwarded to the House of Delegates of the state society and then after proper analysis are sent to the delegates of the A. M. A.

The criticism is often made, what is the A. M. A. doing about this or that; what is the state society doing about it? The explanation might be given that the state society is a product of the county societies and is obliged to do their bidding. The county society is the governing, basic, fundamental unit that should instruct and guide, and direct the efforts of the officials of your state organization.

With the enthusiasm, the new ideas, and the urge of the returning veterans I predict that our county societies will grow, develop, and direct medical organizations with new life and with a constant change for the better in the years to come.

Respectfully submitted,
EDWARD H. WELD, M.D.,
*Councilor-at-Large.*

## REPORT OF COMMITTEE ON MEDICAL SERVICE AND PUBLIC RELATIONS

To the Members of the House of Delegates:

Since its creation in 1944, the principal interest and activity of this committee has been socialized medicine and the Wagner-Murray-Dingell Bills. As this is written, the WMD proposals for national compulsory health insurance are in their third edition in the form of S. 1606, which was introduced in November, 1945, with the endorsement and approval of the President of the United States. S. 1606 is destined to be the first of the WMD Bills to receive committee action, hearings having been scheduled to begin before the Senate Committee on Education and Labor on April 2, 1946. Requests to send representatives to testify orally have been made to Senator Murray, Chairman of the committee and co-sponsor of the bill, by this and most of the other state medical organizations, but it now appears that representatives of national organizations and governmental agencies only will be permitted to testify orally. Other interested groups have been invited to file written statements to be included in the record. It is of course impossible to predict what action will be taken either by the committee or by the Senate itself. It does appear quite likely, however, that the summer adjournment of Congress will come before the bill can possibly progress very far beyond the hearing stage. The developments of the next few weeks will provide the first positive indication as to the relative strength of the advocates and opponents of the program. Meanwhile progress continues with increasing rapidity in forging the most potent of all weapons against socialized medicine: effective voluntary plans for the prepayment of medical expense.

Since a Committee on the Study of Prepayment Plans for Medical and Surgical Care has been functioning for over a year and a half, this committee has not itself been active in that field. However several members of this committee are also members of the committee on prepayment plans, and we have thus been able to keep constantly informed of the activities of the latter group, and to cooperate with it.

Many months ago, this committee became convinced that expert consultation and guidance in the field of public relations would be most beneficial to the society and its membership, and to the public as well. Consequently the committee, at the direction of the Council, made numerous contacts and inquiries in an effort to secure competent assistance in this very important and highly specialized field. The search has resulted in the retention by the Society, with the approval of the Council, of Lawrence C. Salter and Associates, for a period of one year from April 1, 1946, for the purpose of assisting the Society in planning and executing an expanded program of public relations. The committee feels that the organization selected is eminently qualified to do the job contemplated. Mr. Salters was for more than seven years Director of Public Relations for the American Medical Association. His associate, Mr. James C. Leary, under whose personal supervision the Society's program will be conducted, was for ten years Science Editor of the Chicago Daily News. He has had broad experience in the fields of medicine, science and public relations, and has a wide acquaintanceship among medical men. The Committee believes that these men abundantly possess the experience and special skills to perform a service of genuine benefit to the Society, and to coordinate and utilize to greatest advantage many of the Society's present activities which are essentially of a public relations character.

The committee has also attempted to maintain and improve cordial relations with a multitude of social, civic and governmental groups and activities. In cooperation with the Educational Committee, we have tried to keep abreast of the constantly rising demand for speakers on various phases of medical service and economics. Under wartime conditions, this has been exceedingly difficult, but it is hoped that as the release of medical officers from the armed services continues, the number of qualified speakers available will materially increase.

In its many activities, this committee has enjoyed the cooperation of numerous other committees, and of many individual physicians to whom the time involved represented a considerable hardship. For this spirit of cooperation the committee is genuinely grateful. It is especially indebted to Mr. John W. Neal whose able efforts have greatly extended the Committee's field of activity.

Respectfully submitted,
JAMES H. HUTTON, M.D.,
*Chairman*
E. S. HAMILTON, M.D.,

ROBERT S. BERGHOFF, M.D.,
E. P. COLEMAN, M.D.,
PERCY HOPKINS, M.D.,
HAROLD M. CAMP, M.D.,
JOHN W. NEAL.

## REPORT ON COMMITTEE ON PROFESSIONAL DEMEANOR

To the Members of the House of Delegates:

The work of the Committee on Professional Demeanor has almost reached the vanishing point in down state areas. During the past year the committee has responded to many calls in Cook County from men who were threatened, or who had suits already instituted, and it is pleasant to note that good results have usually followed such conferences. We have worked closely with the Counselor of the State Society, as well as others who are interested in protecting our members against blackmail, and the saving of their funds where suits are in progress.

We learn from the best sources available, that there are now pending in the courts of Cook County, approximately 60 malpractice suits of all descriptions, about 50 per cent of these cases were instituted the past year, your committee having direct knowledge of about half this number. The number of cases in the down-state courts is much smaller, and no one has requested assistance.

It is a satisfaction to note that a steadily increasing number of our members carry Medico-Legal protection, and are thus in position in case of need to secure immediate help; however, in event of threats or a suit, the support of one's colleagues is invariably a source of comfort and reassurance.

Respectfully submitted,
OSCAR HAWKINSON, M.D.,
*Chairman.*
A. L. NICKERSON, M.D.,
PLINY R. BLODGETT, M.D.,
T. B. WILLIAMSON, M.D.,
D. P. POND, M.D.,
RALPH McREYNOLDS, M.D.,
*Committee on Professional Demeanor.*

## REPORT OF COMMITTEE ON ARCHIVES

To the Members of the House of Delegates:

During the life of this Committee the burden of work has fallen upon one of its members, Dr. Carl E. Black, Jacksonville, who died January 13, 1946. The remaining members of the Committee have agreed upon this memorial:

Whereas, Dr. Carl E. Black for many years, upon his own initiative, secured photographic, biographic and other data of interest to the medical profession of Illinois, and

Whereas, Dr. Black continued his activities as a member of the Committee on Archives, and

Whereas, Dr. Black has donated to the Illinois State Medical Society his private collection which is now housed in the Centennial Building in Springfield, and

Whereas, Dr. Black has been called by The Great Physician to his final reward bringing sadness to our hearts;

Be It Hereby Resolved, that this resolution be made a part of the annual report for 1946 and that a copy thereof be sent to his widow.

Be it Further Resolved, that 1946-47 be designated "Dr. Carl Black Year" for the collection of material for the Society's Archives.

Respectfully submitted,
D. D. MONROE, M.D.,
*Chairman.*
P. J. McDERMOTT, M.D.,
*Committee on Archives.*

## REPORT OF THE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

To the Members of the House of Delegates:

The data upon which this report is based were obtained chiefly from the Hospital Number (March 31, 1945) and the Educational Number (September 1, 1945) of the Journal of the American Medical Association.

### I. MEDICAL EDUCATION.

The War has had a profound effect on medical education in this State and throughout the entire country.

1. The adoption of the "accelerated program" by practically all medical schools has resulted in a scrambling of the calendars of these schools in a manner never known before. Unless one consults a prepared list it is not possible to know when any given school will graduate a class.

2. As a result of the accelerated program the medical schools of the United States have graduated four classes totalling 20,662 persons in three years. This was an increase of 5,127 graduates in medicine in the three year period ending June 30, 1945, as compared with the preceding, pre-war three year period ending June 30, 1942.

3. Recent policies of the Government indicate that it will be very difficult during the next few years to fill the freshman classes in medical schools. Nearly 80 per cent of all medical students have been in the Army and Navy programs with more than 90 per cent of the juniors and seniors in the classes of 1944 and 1945 in these groups. Both these programs have been discontinued. If present policies are rigidily enforced, medical schools must obtain new students from sources that supplied only about one-fourth of the classes in the past two years. One of the consequences, therefore, seems to be inevitable: Either there will be too few applicants to fill the freshman classes of all schools with adequately trained students, or some schools will admit inferior applicants.

4. Under prewar standards of admission, 98 per cent of all medical students had at least three years of college work, and a majority had had four years. Modern medical training is based upon that amount of

previous education. The Army proposed that prospective medical students be required to complete their pre-medical basic college training in fifteen months of an overcondensed curriculum. As a result of this deficient premedical training, it is a general impression (perhaps without sufficient objective data) among most medical teachers that students who have entered medical schools during the past two years are inferior in knowledge, in capacity for study, in poise and stability, when compared to those who entered prior to 1942. The medical profession may well be concerned over the quality of the freshman medical students admitted during the next few years and, over the quality of the physicians of the future.

5. The number and percentage of women entering medical schools in Illinois and throughout the United States have increased as a result of the depletion of the reservoir of men students during the War. The distribution of medical students by sex in the classes of 1944-1945 was as follows:

TABLE I.

| | *Students* | | |
|---|---|---|---|
| | *Men* | *Women* | *Per Cent Women* |
| United States | 22,676 | 1,352 | 5.63 |
| Illinois | 1,723 | 91 | 5.02 |
| | *Graduates* | | |
| | *Men* | *Women* | *Per Cent Women* |
| United States | 9,791 | 514 | 4.99 |
| Illinois | 715 | 26 | 3.51 |

6. It has been estimated that in the postwar period approximately 30,000 more physicians will be needed than in the prewar period in order to meet the increased needs of the Veterans' Administration, of the Army and Navy and of compulsory military service if that should be put into effect. At the present accelerated rate of graduation about 40,000 students would receive the M.D. degree between 1942 and 1948. In that period also about 24,000 physicians will have died. This will leave a net gain of only about 16,000, or approximately one-half the actual need. This increased demand will have to be met in spite of the difficult conditions mentioned in paragraph 4 above.

7. Because of the interruption of studies of young men as a result of induction into the Armed Forces and because of the inadequate premedical preparation of most of the prospective students, it has been proposed to award high school and even college credits on the basis of examinations rather than on the basis of course credits, as has been done heretofore. Such a program would be sound and just if the examinations are made sufficiently comprehensive.

8. Prior to 1942 a very large percentage of medical students were compelled to finance their professional education in whole or in part by student loans or by outside work. During the War, 80 per cent or more of the students in medical schools were financed by the Army or Navy. With the discontinuance of these programs, and this type of aid, medical students will again be confronted with financial problems. It has been proposed that Federal funds be made available for medical students. Government aid for this purpose should be in the form of loans rather than as outright scholarships, if medical education and the future medical profession is to retain its former freedom.

II. HOSPITALS.

The status of hospitals in Illinois in 1929, 1934 and 1944 is shown in Table II. It furnishes comparative data on the condition of hospitals (1) in the year immediately preceding the depression, (2) in the depth of the depression and (3) in a year of war-time prosperity.

TABLE II

| | *No. hospitals* | *No. beds* | *Patients admitted* | *Average daily census* | *Per cent occupancy* |
|---|---|---|---|---|---|
| Government Hospitals— | | | | | |
| 1929 | 85 | 40,337 | | 35,688 | 88.5 |
| 1934 | 75 | 46,276 | 146,315 | 43,883 | 94.7 |
| 1944 | 88 | 74,893 | 234,484 | 61,283 | 81.9 |
| Non-government Hospitals— | | | | | |
| 1929 | 268 | 23,437 | | 15,666 | 66.7 |
| 1934 | 245 | 23,650 | 360,877 | 11,855 | 50.1 |
| 1944 | 239 | 26,449 | 683,993 | 20,491 | 77.5 |
| Total—all hospitals— | | | | | |
| 1929 | 353 | 63,774 | | 51,354 | 80.5 |
| 1934 | 320 | 69,926 | 506,392 | 55,788 | 79.7 |
| 1944 | 327 | 101,342 | 918,447 | 81,774 | 80.7 |

In Table III are shown the percentage changes in number of hospitals, number of hospital beds, patients admitted, average daily census and per cent occupancy in the hospitals in Illinois in 1929, 1934 and 1944. Both tables (II and III) show a marked shift of patients from non-government to government hospitals from 1929 to 1934 and a reverse shift from 1934 to 1944. During these two periods the per cent occupancy of all hospitals (government and non-government) changed relatively little; e.g., 80.5 per cent in 1929, 79.9 per cent in 1934 and 80.7 per cent in 1944.

TABLE III.

| | 1929-1934 | 1934-1944 | 1929-1944 |
|---|---|---|---|
| Government hospitals— | | | |
| Number of hospitals | —11.76 | +17.35 | + 3.53 |
| Number of beds | +14.65 | +61.80 | +85.66 |
| Patients admitted | | +60.26 | |
| Average daily census | +22.82 | +39.80 | +71.72 |
| Per cent occupancy | + 6.20 | —12.60 | — 6.60 |
| Non-government hospitals— | | | |
| Number of hospitals | — 8.58 | — 2.46 | —10.82 |
| Number of beds | + 0.91 | +11.82 | +12.81 |
| Patients admitted | | +89.53 | |
| Average daily census | —24.34 | +56.30 | +30.80 |
| Per cent occupancy | —16.60 | +27.40 | +10.80 |
| Total—All hospitals— | | | |
| Number of hospitals | — 9.35 | — 2.14 | — 7.37 |
| Number of beds | + 9.65 | +45.00 | +58.95 |
| Patients admitted | | +81.09 | |
| Average daily census | + 8.42 | +47.00 | +59.70 |
| Per cent occupancy | — 9.80 | + 1.00 | + 0.20 |

The Illinois State Department of Public Health

is completing a comprehensive survey of the hospitals of this State. The very valuable report of this survey will soon be available to the members of the Illinois State Medical Society.

This report of the Committee on Medical Education and Hospitals is intended to be informational only. No recommendations are presented for action by the House of Delegates.

Respectfully submitted,
JAMES P. SIMONDS, M.D.,
*Chairman.*
H. O. MUNSON, M.D.,
W. R. MARSHALL, M.D.,
*Committee on Medical Education and Hospitals.*

## REPORT OF THE COMMITTE ON MEDICAL BENEVOLENCE

To the Members of the House of Delegates:

This report covers the period from May 1, 1945, to April 30, 1946.

There were nine recipients of assistance during the fiscal year. One recipient is back in the practice of medicine and stated that he no longer needed assistance. Three recipients died during the year. Two applicants are under investigation.

It should be noted that the Woman's Auxiliary to the Illinois State Medical Society are continuing their interest in and support of this activity.

The expenditures during the year were $2,390.00.

Respectfully submitted,
G. HENRY MUNDT, M.D.,
*Chairman.*
CHARLES H. HULICK, M.D.,
H. M. CAMP, M.D.,
*Secretary.*
*Committee on Medical Benevolence.*

## REPORT OF COMMITTE ON CONSTITUTION AND BY-LAWS

DR. CHARLES P. BLAIR, Monmouth: Your Committee on Constitution and By-Laws begs to submit the following for your consideration:

*State Society Constitution*: Article IV, Section 1. We wish to change this in order that men returning from service who are serving as residents in hospitals can become members of the component societies in which they are located for one-half the fee being set by the House of Delegates. We wish to change the constitution so that men practicing in state institutions who are not registered in Illinois but are licensed by some examining board duly authorized may become members. The changes proposed in Article IV are as follows:

*Present reading*

*Section* 1. This society shall consist of members, emeritus members, honorary members and guests.

*Proposed changes*

*Section* 1. This society shall consist of members, emeritus members, *resident members,* honorary members and guests.

*Present reading*

*Section 2. Members.* The members of this Society must hold the degree of Doctor of Medicine or its equivalent, be members in good standing of the component society, and citizens of the United States, and be licensed to practice medicine in Illinois.

*Proposed changes*

*Section* 2. *Members.* The members of this society must hold the degree of Doctor of Medicine or its equivalent, be members in good standing of the component society, and citizens of the United States, and be licensed to practice medicine in Illinois, *or be licensed by some other duly authorized licensing board.*

*Present reading*

*Section* 3. *Emeritus Members.* No change.

*Present reading*

*Section* 4. Present Section 4 becomes Section 5.

*Proposed changes*

*Section* 4. *Resident Members.* Resident members shall be those physicians of Illinois, holding the degree of Doctor of Medicine or its equivalent, members in good standing of the component society, citizens of the United States, licensed to practice medicine in Illinois, and who are serving as Residents in approved hospitals in this state. They shall have all the rights and privileges of membership and shall pay dues equal to one half the per capita amount fixed by the House of Delegates for members.

*Present reading*

*Section* 5. Present Section 4 becomes Section 5. *Honorary members.*

*Section* 6. Present Section 5 becomes Section 6. *Guests.*

*Present reading*

*Article VI. The Council*

*Section* 1. Page 5. The Board of Trustees, or, as in this Constitution and By-laws designated, the Council whose duties are executive and judicial, shall consist of thirteen councilors elected by the House of Delegates, and three councilors-at-large with the president, president-elect and secretary-treasurer ex-officio. Besides its duties mentioned in the By-laws etc., etc.

*Proposed changes*

*Section* 1. The Board of Trustees, or, as in this Constitution and By-laws designated the Council whose duties are executive and judicial, shall consist of *sixteen* councilors elected by the House of Delegates (*six shall be chosen from District Number Three and one from each of the other ten districts, these districts of the geographical area as of May,* 1946), and three councilors-at-large with the president, president-elect and the secretary-treasurer ex-officio. Besides its duties mentioned in the By-laws, etc., etc.

*Present reading*

*Article IX. Officers*

*Section* 1. The officers of this Society shall be a president, a president-elect, a first vice-president, a second vice-president, a secretary-treasurer, thirteen councilors and three councilors-at-large.

*Proposed changes*

*Section* 1. The officers of this Society shall be a

president, a president-elect, a first vice-president, a second vice-president, a secretary-treasurer, *sixteen* councilors and three councilors-at-large.

So far as the constitution of the county societies is concerned, we are instructing that the local constitution for county societies must be changed to fit in with the state constitution.

*Model Constitution for County Societies*

*Present reading*

*Article III. Eligibility*

Every legally registered physician who holds the title of Doctor of Medicine, or its equivalent, and a citizen of the United States, who resides and practices in ..... County, shall be eligible for membership if he is in good moral and professional standing, and does not support, practice, or claim to practice any exclusive system of medicine.

*Proposed changes*

Every legally registered or duly licensed physician who holds the title of Doctor of Medicine, or its equivalent, and a citizen of the United States, who resides and/or practices in ..... County, shall be eligible for membership if he is in good moral and professional standing, and does not support, practice, or claim to practice any exclusive system of medicine.

The next proposal deals with the By-laws of the county societies.

*Model By-Laws for County Societies*

*Present reading*

*Chapter I. Membership*

*Section* 1. (*page* 5)

The society shall be the sole judge of the qualifications of its members, but as it is the only door to the State Medical Society and to the American Medical Association for physicians within its jurisdiction, every reputable and legally qualified physician of ..... County shall be eligible for membership if he fulfills the requirements given in Article III of this constitution.

*Proposed changes*

The society shall be the sole judge of the qualifications of its members, but as it is the only door to the State Medical Society and to the American Medical Association for physicians within its jurisdiction, every reputable and legally qualified, *or duly licensed physician* of ..... County shall be eligible for membership if he fulfills the requirements given in Article III of this constitution.

*Present reading*

*Chapter I. Section* 2. (page 5). A candidate for membership shall make application in writing and shall state his age, his college and date of graduation, the place in which he has practiced, and the date of registration in this state. The application must be accompanied by the admission fee and must be endorsed by two members of this society. It shall be referred to the board of Censors (or membership committee), who shall inquire into the standing of the applicant, assure themselves that he or she is duly registered according to the laws of the State and report at the next meeting, etc., etc.

*Proposed changes*

A candidate for membership shall make application in writing and shall state his age, his college and date of graduation, the place in which he has practiced, and the date of registration in this State, *or the date of license by a duly authorized board of licensure.* This application must be accompanied by the admission fee and must be endorsed by two members of this society. It shall be referred to the board of Censors (or membership committee), who shall inquire into the standing of the applicant, assure themselves that he or she is duly registered according to the laws of the State, *or is duly licensed,* and report at the next meeting, etc., etc.

THE PRESIDENT: This will be referred to the Reference Committee.

DR. H. K. SCATLIFF, Chicago: Do we understand that these men are to be admitted if they are licensed by a board of licensure? What type of membership will they have?

DR. BLAIR: They are to be admitted as members. There are many men in some districts who are engaged in state or federal work, men of high type or caliber, who have no access to the state society except being asked in to the scientific session, and they have no standing in state societies or the American Medical Association. The men in the counties in which this condition exists are anxious, as are the men themselves, that they be admitted to organized medicine.

DR. HAMILTON: This will be referred to a reference committee.

THE PRESIDENT: To the Committee on Miscellaneous Business.

DR. G. HENRY MUNDT, Chicago: There is another thing that came up in this report of the Committee that I think has to be definitely clarified and that is the term residents. There are a number of instances in which men are held to be residents in which they are only house physicians. If I am not mistaken, the Committee has in mind bona fide residents who are being trained in some special field of medicine. I think the Committee will have to bear that in mind and be able to define residents.

DR. R. K. PACKARD, Chicago: We have the report and it is to be referred to the Reference Committee automatically. Every member of the House of Delegates has a right to go and present his opinion to the Reference Committee. I move that we proceed to the regular order of business.

DR. C. PAUL WHITE, Kewanee: As Chairman of the Committee on Miscellaneous Business, may I suggest that any man who has a criticism prepare it in writing.

THE PRESIDENT: You are supposed to have a hearing to which these men can come.

DR. P. E. HOPKINS, Chicago: I have before me the list of reference committees, and Sub-committee "E" is to receive the report, among others, of the Constitution and By-Laws Committee. This matter goes to that Committee of which Dr. Templeton is chairman.

THE PRESIDENT: We will continue with the reports, and the sub-committee "E" will receive this report instead of the Committee on Miscellaneous Business.

## REPORTS OF COUNCIL COMMITTEES

### REPORT OF THE EDUCATIONAL COMMITTEE

To the Members of the House of Delegates:

"The Growth of An Idea"

In this nineteenth annual report to the House of Delegates, we desire to show the progress which has been made in the activities of the Educational Committee, and show the growth of an idea which was conceived by some of the farseeing doctors of Illinois more than twenty years ago.

The office of the Committee has become a source of information to the public as well as to the doctors of Illinois. Our work has been observed by many other states and our help has been given to a number of state medical societies desiring to inaugurate a similar program.

An effort has been made to assist every person who has telephoned or come to the office regardless of the type of information they were seeking. A telephone call or visit to the office of the Educational Committee may be the only contact a person will have with organized medicine. We have felt it important to make friends and to make certain that no one left the office or hung up a receiver feeling that they had not been helped.

Now that the war has been successfully concluded the Committee shall endeavor to enlarge its Speakers' Bureau and its Radio Programs. Both have been necessarily curtailed these last four years. However, during that period we have extended our relationships with lay organizations in Illinois, and we have not lost ground. We are ready to go forward and once more give excellent service to clubs and schools.

A resume of the salient activities of the Committee for each of the past nineteen years will disclose the results of ideas conceived by the Committee.

1928

25—Exhibits of health posters were collected from various agencies in the country, mounted and loaned to schools of the state.

96—Radio programs were arranged.

39—Newspapers used the health column furnished by the Committee.

24—Popular health articles were secured for publication in the Chicago Herald and Examiner.

1929

Through the efforts of the Committee, the Illinois Congress of Parents and Teachers for the first time recommended to their local associations that pre-school child examinations be given by the family physicians in their private offices rather than in clinics.

Began regular programs over radio stations WGN and WJJD.

Cooperated with the Chicago Woman's Club in outlining educational activities regarding cancer.

1930

Committee secured obstetricians to check over and revise letters regarding prenatal care which were distributed by the State Department of Health.

200—Schools, clubs and churches were furnished health programs in connection with Health Promotion Week.

Illinois Federation of Women's Clubs supported the Illinois State Medical Society in opposing the Sheppard-Towner Act and Anti-vivisection legislation.

1931

Cooperated with the Chicago Pediatric Society in sponsoring a Young Mothers' Hour over the radio station WJJD. Talks were given every morning at the same hour over a period of four years.

24—Package libraries on State Medicine were furnished debating teams of colleges in four states.

4,000—cards, representing roster of Chicago Medical Society, were indexed and filed according to Senatorial Districts for the Legislative Committee.

Inaugurated the furnishing of material to Home and Farm Bureaus.

1932

533—Programs were given over stations WGN and WJJD.

Series of talks for expectant and young mothers were arranged for Marshall Field & Co. store in Chicago.

100—Newspapers now receiving regular releases, including two Greek newspapers.

Material was furnished for a Child Health Magazine section to the Sunday Chicago Herald and Examiner.

A talk on the work of the Committee was presented at the Annual Meeting of the Illinois Tuberculosis Association and the Secretaries Conference of the Minnesota Medical Association.

1933

Revised diet lists for children used by the Child Hygiene Division of the State Department of Public Health.

485—Speakers scheduled for lay organizations.

561—Radio programs given over WAAF, WGN, WJJD and KYW.

Cooperated with YOUTH WEEK by furnishing speakers for schools.

Cooperated with the special committee of the Council to outline a program for Crippled Children's Clinics.

Paper on the work of the Committee was presented to the Annual Meeting, Illinois State Nurses Association.

1934

A series of popular health programs were arranged for the Y. M. C. A.'s of Chicago for noon and evening meetings.

Four programs a week arranged for the Hall of Science, Century of Progress.

Began furnishing material to libraries of the State and Red Cross.

A talk explaining the work of the Committee was

All State Legislators are receiving material from the Committee.

## SPEAKERS

The Committee has endeavored to fill all requests for health programs which came from lay organizations in the state. This was extremely difficult due to the fact that many doctors were still in service, others had just returned and were not ready to participate, while some were too busy with the extra load which had been placed upon them. In spite of these handicaps, ONE HUNDRED AND EIGHTY-FOUR doctors addressed women's clubs, schools, parent teacher associations, men's clubs, church groups, etc. During the summer weekly popular health talks were scheduled for the Museum of Science and Industry.

The subject of socialized medicine was requested by some groups, a number of which had both sides of the subject presented. The Committee was responsible for fifty-six such programs. In addition to speakers on the topic, the Committee compiled and gave or loaned more than 300 package libraries on socialized medicine to legislators, women's clubs, physicians, students, chambers of commerce, state medical societies.

20,000 pamphlets from the National Physicians' Committee were mailed with other releases from the Committee during the year.

A record has been made of all contributions sent by the Illinois Physicians' Committee to the National Physicians' Committee.

A speaker on socialized medicine was suggested to the Department of Political Science of Northwestern University for a radio debate. Announcements of this broadcast as well as one other on the subject were sent to our mailing list.

## INFORMATION TO THE PUBLIC:

160,340—Releases to our mailing list of lay leaders.

2,487—Releases to House Organs.

10,000—Releases to Industrial Plants.

13,452—Releases to newspapers.

45,180—Releases to schools—many schools are using the material in science, biology and physical education Classes.

In addition to the material prepared by the Educational Committee for release, splendid use has been made of that prepared by other authentic sources:

"Cancer" pamphlets sent to all doctors of the state.

"Back to School" sent to all parent teacher associations and teachers.

Three popular pamphlets on "Infantile Paralysis" were sent during the polio epidemic last summer.

List of approved films and visual education material were sent to all schools, health chairmen and program chairmen of organizations.

Bibliography of health education material was furnished all schools.

Whooping cough pamphlets and Nutrition booklet were sent to Parent Teacher Associations and schools.

Furnished thousands of pieces of literature to Summer Round-Up Chairmen for distribution to mothers of children entering first grade.

## AID TO COUNTY MEDICAL SOCIETIES

353—Notices for Franklin County Medical Society sent to doctors.

229—Notices for Randolph County Medical Society.

124—Notices for Lee-Whiteside Joint County meetings.

513—Notices for LaSalle County.

715—Notices for Bureau County.

126—Notices for Bureau and LaSalle joint meeting.

444—Notices for Henry County Quarterly meeting.

131—Notices for Williamson County.

844—Notices for St. Clair County program on obstetrics.

## PUBLICITY GIVEN TO MEDICAL SOCIETY MEETINGS

12—Releases regarding North Shore Branch.

215—Releases regarding Henry County.

240—Releases regarding LaSalle County.

42—Releases regarding Bureau County.

86—Releases regarding Randolph County.

40—Releases regarding Lee and Whiteside Counties.

114—Releases regarding Southern Illinois Medical Association.

80—Releases regarding St. Clair County Medical Society.

144—Releases regarding Chicago Medical Society Conference.

45—Releases regarding McLean County Crippled Children's Clinic.

82—Releases regarding Post-Graduate Conference, Mt. Vernon.

125—Releases regarding Post-Graduate Conference at Galesburg.

150—Announcements to presidents and secretaries regarding Mt. Vernon meeting.

## RADIO

The Committee made arrangements to have the electrical transcriptions prepared by the American Medical Association used over radio stations in Peoria, Springfield, Herrin, over the sponsorship of the local county medical societies. These programs have been going on for several months. The Committee sent the schedule of programs to all on its mailing list asking these prominent persons to send comments to the stations.

## "DO YOU KNOW" ARTICLES

The Secretary of the Committee has written the "Do You Know" column on the following topics—Respect Cancer, Mumps Are Trump, Malaria Mosquitoes, Rabies, What is My Outlook, Doctors on Call, Less Noise, Sense and Sun, Medicine and War Wounded, Away with Flies, Beneficial Sunlight, Alcoholism, July, Stubborn Ringworm, Accidents Do Happen, Time for Corrections, Poison Ivy, Hay Fever, Safe Canning, How Old Are You, Physical Fitness, Cancer Not Seasonal, Nasal Medication, Diphtheria Warning, Arthritis, Fall is Here, Halitosis, Fire Prevention, Felons, Medical Terms, Hospital Visits, Physical Therapy, Hunting Season, Think of the Children, Varicose Veins, Tuberculosis, Accidents, Colds are Prevalent, Pneumonia, Sinus Infections, Rheumatic Fever, Health and Cleanli-

ness, Percussion Eye Injuries, Pain A Warning, Periodic Health Examinations, Swollen Glands in the Neck, Conserve Your Heart, Pituitary Gland, March Birthdays, The Thyroid Gland, Appendicitis, Your Arteries, Some Important Tests, Diphtheria Prevalent, Cancer, Measles Again, What's My Blood Pressure.

SCIENTIFIC SERVICE AND POST-GRADUATE WORK

The work of these two committees is carried on by the Educational Committee office. The reports show that this service has been needed and appreciated by many counties. Many county societies are planning to resume their monthly meetings and no doubt will make additional calls upon the Committee for assistance in arranging programs.

MISCELLANEOUS

The Secretary has attended numerous committee meetings with representatives of other organizations. She has served on the Advisory Board of health committees of the Illinois Congress of Parents and Teachers and the American Cancer Society.

Respectfully submitted,
R. R. FERGUSON, M.D.,
*Chairman.*
JAMES H. HUTTON, M.D.,
*Vice Chairman.*
ROBERT S. BERGHOFF, M.D.,
CHARLES P. BLAIR, M.D.,
C. PAUL WHITE, M.D.,
JEAN McARTHUR,
*Secretary.*
*Educational Committee.*

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## REPORT OF THE SCIENTIFIC SERVICE COMMITTEE

To the Members of the House of Delegates:

Since our last report the Scientific Service Committee has continued the servicing of our county societies with scientific programs. The following counties have secured speakers:

Vermilion, Will-Grundy, Madison, Mercer, Champaign, Morgan, LaSalle, Marion, Bureau, Kankakee, Henry, Randolph, Greene, Franklin, Macon, Peoria, Logan, Fulton, McLean, Macoupin, Piatt, Rock Island, DeKalb, DuPage, Whiteside, Lee, Monroe, McDonough, Winnebago, St. Clair, Wiliamson and the Iowa Illinois Central District Medical Association and the Southern Illinois Medical Association. A total of 140 speakers were scheduled by the Scientific Service Committee to present scientific papers before medical socities. Will-Grundy was supplied with weekly and a number of other societies with monthly scientific programs.

The coming year will be one of renewed and unusual activity. Our returned veterans in resuming practice, are eager for the newer developments in civil medicine. This information we are able and anxious to supply through two different sources:

1. Through the monthly scientific meetings of the local county societies;

2. Through post-graduate conferences, ten of which have been authorized by the Council and all of which will be conducted this year.

We should like to point out to our county medical societies that our returned veterans all over this state, have themselves gathered experience which is very valuable to us in civil practice and these men should be on our speakers list. If the county secretaries will supply Jean McArthur with the names of these men and the subjects on which they are prepared and willing to speak, we will see that they are added to the new list of suggested speakers which we hope to publish this fall.

And so, Members of the House of Delegates, and our membership at large, we want you to know that we are embarking on a new and important year and are prepared to assist all county medical societies with scientific programs as well as publicity for these programs upon request.

Respectfully submitted,
ROBERT S. BERGHOFF, M.D.,
*Chairman.*
JAMES H. HUTTON, M.D.,
J. S. TEMPLETON, M.D.,
F. H. FALLS, M.D.,
WALTER STEVENSON, M.D.,
HARLAN ENGLISH, M.D.,
HAROLD M. CAMP, M.D.,
JEAN McARTHUR,
*Secretary.*
*Scientific Service Committee.*

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## REPORT OF THE POST-GRADUATE EDUCATION COMMITTEE

To the Members of the House of Delegates:

We are reporting to you herewith upon the activities of your Post-Graduate Committee for the past year and upon our plans for the coming year.

During the current year, one day post-graduate conferences were held in the following cities:

Galesburg—with the following program presented by the staff of Mayo General Hospital:

"Psychiatric Factors Delaying Recovery"—Capt. Leo A. Kaplan.

"Thrombophlebitis"—Capt. David I. Abramson.

"Traumatic Aneurysms"—Maj. Harris B. Shumaker.

"Fractures of the Upper Shaft of Femur"—Lt. Col. Philip Lewin.

"The Use of Penicillin"—Capt. Charles M. Schroeder and Capt. Norman T. Welford.

"Ruptured Intervertebral Disks—Surgical Aspects"—symposium led by Capt. I. Joshua Speigel and Maj. Richard E. Kinzer.

Mt. Vernon—with the following program:

"Penicillin"—Lt. Col. Earl R. Denny.

"Sterility"—Williard C. Scrivner.

"Recent Advances in Treatment of Essential Hypertension"—Edward W. Cannady.

"Treatment of Abortion"—Frank F. Maple.

"Management of Sinus Disease"—G. Henry Mundt.

"Treatment of Compound Fractures"—Edward L. Compere.

"Recent Advances in Endocrinology"—Willard O. Thompson.

"Rheumatic Fever in Children"—H. W. Elghammer.

"Future of Medicine"—Edwin S. Hamilton.

"Reminiscence of 54 Years in the Practice of Medicine"—Andy Hall.

These post-graduate conferences have proven their value in previous years, including the difficult war years. Now that the war is over, these programs will be expanded in number and in scope.

The Council of the Illinois State Medical Society has recently authorized ten such conferences for this coming year. Approximately half of them will be held before fall, the remainder early in the winter. In view of the fact that our returned veterans are anxious to be refreshed with the newer aspects of civil medicine, these conferences will be full day, rather than half day sessions. They will probably include at least three speakers in the morning, three or four in the afternoon, plus a full hour devoted to round tables or panel discussions of all lectures given during the day. The program will conclude with a dinner and a guest speaker.

Your committee suggests that councilors and county secretaries contact Jean McArthur's office requesting such a conference, giving preference as to possible dates and selection of the site.

Your committee is looking forward with interest and anticipation to a busy and important year.

Respectfully submitted,

ROBERT S. BERGHOFF, M.D.,
*Chairman.*

R. R. FERGUSON, M.D.,
CHARLES P. BLAIR, M.D.,
FRANK DENEEN, M.D.,
WALTER STEVENSON, M.D.,
C. O. LANE, M.D.,
JEAN McARTHUR,
*Secretary.*
*Post-Graduate Education Committee.*

## REPORT OF THE COMMITTEE ON THE MEDICAL CARE OF PUBLIC ASSISTANCE RECIPIENTS

To the Members of the House of Delegates:

Report of the Medical Advisory Committee to the Illinois Public Aid Commission.

Your Committee desires to submit the following report in reference to the program for the medical care of old age assistance, aid to dependent children, blind and relief, each recipients of public assistance in the state of Illinois. We will also call to your attention some of the legislation recently enacted by the 64th General Assembly of this state. The latter will have particular effect upon the administration of welfare programs as well as the care of these recipients.

The Committee has met at regular intervals with representatives of the Illinois Public Aid Commission and discussed many problems with reference to the medical care of these recipients, likewise current problems of providing for technical advice in connection with the medical programs of county homes.

The case-load is about the same as reported in 1945. The counties of Ford, Jasper, Lake, Piatt, Pope and Cook do not have at this time a Medical Advisory Committee. It is our information that the counties of Ford, Jasper and Piatt are in the process of appointing advisory committees. The County of Cook remains the same as it did in our report to the House of Delegates in 1945. It is now sixteen months since the Committee resigned and the Chicago Medical Society withdrew its approval of the program as it operated in the County of Cook.

In this connection it is to be noted that on January 1, 1945, at which time the Illinois Public Aid Commission announced that it would supplement funds to pay for medical care and hospital bills in those instances where those bills were large and could not be met out of the forty dollar a month grant. The Illinois Public Aid Commission at that time announced that this policy would be put into effect in all the counties of the state except the County of Cook. In the County of Cook these recipients whose illness required hospitalization would be limited to hospitals that give board, room, nursing and medical care for five dollars a day. The Medical Advisory Committee of the Chicago Medical Society were of the opinion that this policy deprived the recipients of the free choice of hospitals and physicians. This was contrary to the principles upon which the program had been developed. There had never been any dispute over the question of fees allowed by this program. The physicians in the County of Cook have always provided the necessary care regardless of the fees. In view of the fact that the present policy placed the hospitals in the position of corporations practicing medicine and it denied the recipients the free choice of hospital and physician, the Medical Advisory Committee resigned and the Chicago Medical Society withdrew its approval of the program as it was to be operated at that time.

Your Committee desires to state that there have been numerous changes in the welfare programs in this state during recent years. It is hard for any physician to appreciate the magnitude of this problem unless he is familiar with the national and state legislation that has been enacted in behalf of the people receiving public assistance during the past twelve years. The social upheaval of 1929 and 1930 left many people depending upon public assistance. The Federal Social Security Act was passed by Congress in 1935. The General Assembly of the State of Illinois passed enabling legislation to comply with the old age category of the Social Security Act on January 29, 1935. It was further amended January 3, 1936. This was one of the first major steps taken in reference to social legislation in this state.

It is now about six years since the Department of Public Welfare of the State of Illinois invited the Illinois State Medical Society to appoint a medical advis-

ory committee to advise and assist them in developing a medical program for the recipients of public assistance in the state of Illinois. It is of historical interest to note that prior to January, 1941, there had not been developed in the state of Illinois a full public aid program. Prior to that time assistance to all persons in need other than those eligible for old age pension was provided through general relief programs, administered by the state's 1455 local governmental units, with the state participating through funds allocated by the Illinois Emergency Relief Commission, the administrative agency that preceded the present Illinois Public Aid Commission. In addition to the old age and general relief, the state contributed money toward but did not supervise the county's mothers' pension and blind relief. In the interim since January, 1941, many changes have taken place. The state has passed enabling legislation complying with the Social Security law in regard to aid to dependent children and the blind. The aid to dependent children act became a law in June, 1941, administrative October 1, 1941. This law is broader in scope than the mothers' pension act which it superceded. The blind assistance became a law July 15, 1943, administrative October 1, 1943.

The four major categories, namely, old age pension, aid to dependent children, blind, and general relief, are now consolidated in a single state agency, the Illinois Public Aid Commission. This has resulted in a great administrative economy as well as greater benefits to the needy.

The original contract between the state of Illinois and the Federal government created a partnership in that both governments undertook to share the cost of providing for these recipients. The monthly grant, however, was small. Inasmuch as these funds provided inadequate care, the state of Illinois decided in January, 1945, to pay entirely out of its own resources necessary additional costs to help provide payment for large medical and hospital bills that could not be met out of the forty dollar a month grant. This supplementation of funds has greatly increased the efficiency of the program as well as the benefits to many recipients, physicians and hospitals in the counties in which it is operating.

There is, however, a growing tendency, on the part of a few physicians to request an increase of their fees for the medical care of the recipients. This no doubt is done on the supposition that there is more money available for this service because of the supplementation. The Commission has repeatedly stated that it supplemented funds to aid in the payment of medical care and hospital bills on the premise that the fee schedule developed for the medical care of these recipients would be adhered to. The fee schedule adopted is comparable to that in programs of similar type adopted in other states. The Committee is of the opinion when these physicians realize that the fee schedule is to be adhered to, their practice of submitting increased fees will cease to exist.

The Illinois Public Aid Commission has recently appointed a state advisory committee on general relief. This consists of local officials administering general relief, a committee of eight township supervisors who are to advise the Commission in planning policies of general relief program. The State Commission has now six statewide committees advising on specialized problems of public aid, namely, Advisory Committee on Health, Advisory Committee on the Blind, the Medical Advisory Committee, the Dental Advisory Committee, the Hospital Advisory Committee, and the State Advisory Committe on General Relief.

The Committee has called your attention at different times relative to the codification of all laws pertaining to public aid in this state. This is now in the process of being accomplished. These laws are now scattered throughout the statutes and contain provisions which are now obsolete and overlapping. The 64th General Assembly created an Illinois Public Assistance Laws Commission, which was charged with the duties of studying existing laws and preparing a codification which is to be presented to the 65th General Assembly. The Committee held its first meeting in March, 1946. Much of the legislation throughout the nation today is social. The 64th General Assembly of Illinois enacted over forty bills pertaining to public aid laws and their administration. Thirty-five of these bills were approved by Governor Dwight H. Green. Most of these became effective in July, 1945, thus enabling the state to carry forward the new biennium with various improvements in public aid which were initiated during the past two years.

A Commission has been created by the action of the General Assembly to investigate the facilities for the care of the chronically ill among the indigents. The Committee is to report to the 65th General Assembly in January, 1947. It is our understanding that the Committee has not limited itself to the indigents but extended its investigations into other walks of life in order to help them propose a public policy for the state which will better meet the needs of all persons who are afflicted with chronic illness.

The law pertaining to general relief has been modernized by reduction of residence requirements, by removal of the unworkable ten per cent limitation on administrative expenses, and by clarification of the requirements whereby local units qualify for receipt of the state funds for general relief.

The aid to dependent children, blind assistance and old age pension acts have been revised so as to simplify administration and establish more uniformly eligibility requirements, as well as to provide the basis for giving better care and service to persons without sufficient means for decent livelihood.

The first major attack on chronic illness as a cause of dependency, economic and social maladjustment has been made by the state. The General Assembly enacted bills enabling county governments to convert outmoded poor houses into modern institutions for the care of the destitute, infirm and chronically ill.

The question of status of nursing homes in this state has been one that has been long overlooked. In the past year much work has been done on this subject

by the Committee on Chronic Care of the Institute of Medicine. Largely through the initiative of their study the General Assembly enacted bills licensing and regulating nursing homes. They will be under the supervision of the State Department of Public Health. This should provide not only better nursing care but increased facilities for the recipients of this program as well as for other people who require this type of care.

The aid to dependent children act was amended to permit payment for medical care to the source of care, thus bringing this act into agrement with the old age pension and blind assistance act, which have contained a similar provision since 1943. In addition, the appropriation for the aid to dependent children program makes it possible for the first time since this program began in 1941 to undertake to meet from the appropriation the full budgetary need, including medical care of persons receiving this form of assistance. Because of this appropriation it became possible in September, 1945, to advise local relief authorities that supplementation in this program was no longer needed and to take action to increase grants without regard to a monthly maximum, in order to meet the essential requirements and to make certain the payments to the source of medical care.

The appropriations for the old age pension and blind assistance program are sufficient under existing circumstances to meet the ordinary living expenses of persons benefitting from these programs as well as to continue the medical program as now established. The maximum grant to old age pensioners for expenses other than medical care was increased to $45 per month. The maximum grant to blind assistance remains at $40 per month. Recipients in both programs may continue to receive as much as $75 per month if required for medical care and in addition, payments may be made from state funds under certain circumstances to persons or agencies providing medical care.

The Rennick-Laughlin bills in addition to providing for the conversion of poor houses into moderate facilities for the care of the chronically ill, also make it possible to provide assistance to persons otherwise eligible for old age pension, blind assistance, living in county homes which meet the standards set by the Illinois Public Aid Commission; by providing assistance to residents of public institutions the state of Illinois has led the way by meeting the needs of such persons. The Federal Social Security Act did not provide for such assistance. It is for this reason that assistance to this group of individuals will come entirely from state funds. We are informed that the Social Security Board has indicated interest in the amendments of the Federal laws which will permit Federal participation in the cost of this type of care.

We include with this report three exhibits:

A. Comparison of the peak loads of the four programs in this state in 1935 and 1945.

B. Number of persons receiving public aid in Illinois January 1945 and 1946.

C. Medical expense statistics January, 1946.

EXHIBIT B
NUMBER OF PERSONS RECEIVING PUBLIC AID

| | *Total State* | *Downstate Counties* | *Cook County* |
|---|---|---|---|
| Old Age Pension | | | |
| January 1945 | 123,521 | 79,195 | 44,326 |
| January 1946 | 123,268 | 79,044 | 44,224 |
| Aid to Dependent Children | | | |
| January 1945 | 66,638a | 37,286a | 29,352a |
| January 1946 | 68,928 | 37,221 | 31,707 |
| Blind Assistance | | | |
| January 1945 | 5,238 | 3,305 | 1,933 |
| January 1946 | 5,100 | 3,170 | 1,930 |
| General Relief | | | |
| January 1945 | 56,898 | 26,235 | 30,663 |
| January 1946 | 46,592 | 25,725 | 20,867 |
| Unduplicated Total | | | |
| January 1945 | 236,123 | 142,313 | 93,810 |
| January 1946 | 243,502 | 144,809 | 98,693 |

a—Includes an estimated number of grantee relatives plus children.

EXHIBIT C
MEDICAL EXPENSE STATISTICS
JANUARY, 1946

| | *Old Age Pension* | *Blind Assistance* | *Aid to Dependent Children (2)* |
|---|---|---|---|
| Case load | 123,268 | 5,100 | 20,504 |
| Total payments | $258,113.89 | $7,822.74 | $17,130.56 |
| Total patients | 23,864 | 679 | 1,545 |
| Percentage receiving care | 19.4 | 13.3 | 7.5 |
| Average per patient | $ 10.82 | $ 11.52 | $ 11.09 |
| Average per recipient | $ 2.09 | $ 1.53 | $ .84 |
| Total physician's services | $145,607.35 | $4,094.76 | $11,058.28 |
| Number receiving physician's serv. | 21,033 | 546 | 1,246 |
| Average physician's services per patient | $ 6.92 | $ 7.50 | $ 8.87 |
| Average physician's services per recipient | $ 1.18 | $ .80 | $ .54 |
| Total hospital care | $ 85,596.73 | $2,315.97 | $ 4,048.15 |
| Number of hospital patients | 974 | 32 | 112 |
| Average per hospital patient | $ 87.88 | $ 72.38 | $ 36.14 |
| Total dental care | $ 5,220.11 | $ 180.00 | $ 1,206.25 |
| Number of dental patients | 319 | 19 | 93 |
| Average per dental patient | $ 16.36 | $ 9.47 | $ 12.97 |
| Total oculist care | $ 3,876.29 | $ 78.30 | $ 624.51 |

| | | | |
|---|---|---|---|
| Number of oculist patients | 474 | 12 | 68 |
| Average per oculist patient .$ | 8.18 | $ 6.53 | $ 9.21 |
| Total other care .$ | 17,813.41 | $1,153.71 | $ 193.37 |
| Number of patients receiving other care (1) | 1,064 | 70 | 26 |
| Average per patient receiving other care (1) .....$ | 16.74 | $ 16.49 | $ 7.42 |

(1)—*Includes appliances, nursing services in the home, etc.*

(2)—*In this column, amounts are per case, rather than per individual as in the OAP and BA programs.*

## RELIEF

### Downstate

The program of relief is administered by the local governmental units, the largest unit being that of the Chicago Welfare Administration.

In January, 1945 there were 115 local governmental units out of a total of 1,455 receiving state funds for relief purposes.

In January, 1946 these units were 103. The units were giving assistance respectively to 74.9 per cent and 66.5 per cent of the total number of persons receiving general relief in the state. In January, 1946 the total expenditures for medical care reported by all local relief units was $164,548.13.

## RELIEF

### City of Chicago Welfare Administration

The case load declined during the first eight months of the year at the rate of one per cent a month to a low point of 27,000 persons. The end of the war showed its immediate effect on the assistance rolls in the City of Chicago. In September, 1945 there was an increase in the number of people applying for assistance. This increase was repeated in October, 1945, and has continued since.

It is supposed that one of the major factors accounting for the rise in applications is that many physically handicapped workers who were employed in war production industries were not acceptable to other employers at the termination of the war. They are likewise not eligible to unemployment compensation benefits. They were thus compelled to apply for public aid when their meager resources were exhausted. It is also supposed that other factors accounting for the rise in applications are desertion of heads of families, unmarried mothers who cannot support themselves, and decrease in income in the form of financial aid from relatives no longer able to assist.

Applications from strikers have affected the relief rolls only slightly since in most cases other jobs were found for them during the period when they were unable to return to their regular employment.

Legislation passed by the General Assembly increasing appropriations for aid to dependent children made it no longer necessary for the Chicago Welfare Administration to supplement aid to dependent children's grants.

A few years ago the Chicago Welfare Administration developed a placement service, the function of which was to help find employment for recipients whose physical condition handicapped them from general employment. In this department recipients were carefully examined by the medical division and graded for employment according to their ability to work. This service placed approximately 1,600 persons in private employment in 1945. It placed 3,253 people in 1944, and 8,411 in 1943. The placements were noticeably less because of the decrease in the number of employable persons receiving assistance.

A Home for Convalescent Care was developed by the Chicago Welfare Administration two years ago to provide care for recipients who were discharged from hospitals but not necessarily able to return to their homes. The Home during 1945 provided for an average of 117 persons monthly. Forty-two of these were recipients who had been discharged from Cook County Hospital.

Physicians' Services—The Committee desires to state that during the period from January through December, 1945, fifty-one physicians resigned from the roster to enter military service. The largest number of resignations for military service occurred in 1944. The number of visits made by physicians to recipients on the roster during the past year has continued about the same. There was a slight decline. This, however, was due to the reduction in the number of recipients. We include here a list of home and office visits made during 1944 and 1945.

| | 1945 | 1944 |
|---|---|---|
| Home Visits—Day | 20,520 | 27,014 |
| Home Visits—Night | 401 | 405 |
| Office Visits | 1,051 | 1,113 |
| Total | 21,972 | 28,532 |

The number of obstetrical cases continued to decline through 1945. The Chicago Welfare Administration referred to the Chicago Maternity Center for home delivery service 24 cases in 1945 as compared with 49 in 1944, and 154 in 1943. The total number of obstetrical cases cared for in hospitals with which the Chicago Welfare Administration has an agreement, was 120 in 1945. The number of cases cared for by private physicians in the home was 10.

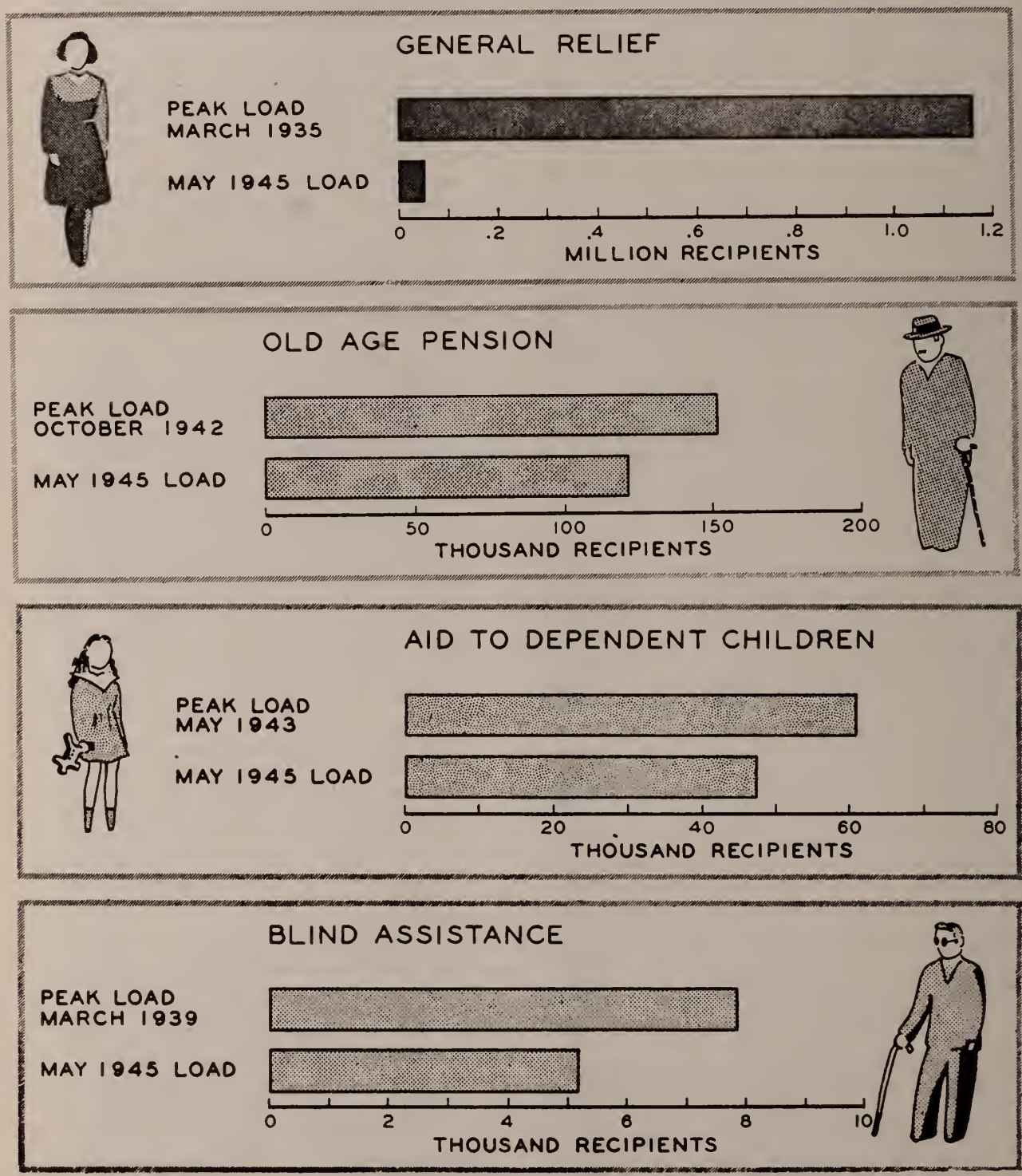
It is to be noted that the recipients hospitalized were cared for in Cook County Hospital and in private hospitals at the rate of five dollars per day. The Chicago Welfare Administration paid $12,374.55 to the County Hospital for 24,312 patient days. They also paid $73,988 for 14,872 patient days in private hospitals.

The number of residents in Oak Forest Infirmary numbered 916 per month in 1945; this is an increase over the monthly average of 714 for the year 1944.

Expenditures increased to $357,012.46 in 1945 from $298,245.55 in 1944.

The Committee desires to include a statement of the

# COMPARISON OF PEAK LOADS OF GENERAL RELIEF, OLD AGE PENSION, AID TO DEPENDENT CHILDREN, AND BLIND ASSISTANCE RECIPIENTS WITH MAY 1945 LOAD



obligations for medical care by type during 1944 and 1945.

| *Type of Care* | 1945 | 1944 |
|---|---|---|
| Total | $539,949.15 | $624,618.92 |
| Clinical Care | 85,309.84 | 115,762.20 |
| Dental Care | 47,763.27 | 51,121.14 |
| Hospital Care | 195,362.55 | 214.909.62 |
| Medical Appliances | 9,759.05 | 12,557.94 |
| Convalescent Care | 101,046.38 | 109,085.15 |
| Physicians' Fees | 44,003.00 | 57,193.50 |
| Home Nursing Care | 10,483.34 | 12,716.52 |
| Drugs | 19,789.82 | 24,148.02 |
| Miscellaneous | 26,431.90 | 27,124.83 |

The Committee desires to state that many of the bills enacted by the 1945 General Assembly have a very important effect on (1) public welfare programs, (2) financing of public welfare services, (3) increased benefits to recipients, and (4) personnel in public welfare agencies. Most of them will have some influence on this program, particularly those affecting the financing of welfare programs, Senate Bill 291 appropriating $23,824.00 for aid to dependent children awards during the biennium, makes an increase of $12,024,000.00 over the amount appropriated for the preceding biennium. These increased grants will make it possible for the City of Chicago Welfare Administration to close approximately 3,000 cases of families who are now receiving assistance to supplement inadequate aid to dependent children's grant and will materially reduce the total welfare case load. Senate Bill 470 reduces the levy for relief in municipalities having a population over 500,000 (Chicago) from a maximum of $6,000,000 per fiscal year to a minimum of $4,000,000. This legislation will have the effect of reducing the relief costs to the City of Chicago and increasing the corresponding share of contribution from the State of Illinois.

This program has now been in operation since 1934. It was organized during the peak load of the depression. The Committee have met at regular intervals with representatives of the Welfare Administration since this program was organized. The program represents what can be accomplished between a county medical society and a welfare administration in trying to help a community project. Much has been gained for the recipients in the way of medical care. The Committee have at all times had three objectives in mind: the health and welfare of the recipients, the interests of the physicians, and the conservation of public funds. The Committee desires to commend the Administration for its efficiency and its interest in the recipients and in the physicians rendering medical care to these beneficiaries. The Committee greatly regretted to see Mr. George J. Klupar, the Commissioner of the City Welfare Administration, resign his position December 31, 1945. He was a most competent administrator. He was possessed of a very broad knowledge of welfare programs, and it was always a great pleasure to discuss medical problems with him. He was succeeded by Mr. Alvin E. Rose, who was formerly associated with the Chicago Welfare Administration in charge of applications for relief.

The Committee is most grateful to Miss Alice Saar, the Director of Medical Relief Service and her assistant, Miss Irene Steinhart.

The Committee are most grateful to the physicians who have rendered medical care to the needy and thereby helped to make this a very valuable service in the community.

Respectfully submitted,

*Committee on Medical Care of Public Assistance Recipients.*

CHARLES H. PHIFER, M.D., *Chairman,*
JOSEPH CHIVERS, M.D.,
JULIUS H. HESS, M.D.,
JAMES H. HUTTON, M.D.,
HAROLD W. MILLER, M.D.,
FRED H. MULLER, M.D.,
WARREN FUREY, M.D.

Summary

1. The cooperation of the members of the medical profession throughout the state in general has been excellent.

2. There is no county in the state where recipients do not receive medical care.

3. The licensing and regulation of nursing homes should materially raise their standard of care for their patients. It should likewise help to provide a much needed community service of this type.

4. The conversion of the county poor institutions may also offer some constructive assistance in the care of the chronically ill patients among other low income groups than the old age assistance.

5. Your Committee thoroughly appreciate the fact that very important parts of the objective of this program, namely, the medical care of recipients and the advice and guidance of the county medical advisory committee, must be rendered by the physicians in their respective communities.

6. There are many problems that constantly arise in this program that need the supervision and assistance of your state medical society.

7. The Committee is deeply conscious of the handicaps associated with rendering medical care to these recipients. We are most grateful to the physicians who assist in the program, either in rendering medical care or serving on county medical advisory committees.

8. The Committee hopes that the appointment of an advisory committee on relief by the Illinois Public Aid Commission may serve to help unify the problems of medical care among the relief recipients. We also hope that it may help to eliminate medical care now rendered in a few of the governmental units by contract practice.

9. The Committee is very sorry that the Illinois Public Aid Commission adopted the policy it did in regard to hospitalization and medical care of recipients in the County of Cook without first discussing its advantages and disadvantages with their state medical advisory committee. It does, however, seem paradoxical

that an administrative agency should ask for the advice and counsel of a state medical society in helping to draft a statewide program for the medical care of public assistance recipients in the state and later when the program was in operation institute a policy pertaining to the medical care of recipients that would deprive over a third of the recipients of the same type of hospitalization and medical care as the remainder of the recipients.

10. This is the policy adopted by the I. E. R. C. in Chicago during the early days of the depression before the Chicago Medical Society had appointed a medical advisory committee to the Chicago Relief Administration. The value and efficiency of the policy has long been questioned by many public citizens as well as members of the medical profession. The Committee doubts its economical value and since it destroys the patient-physician relationship, they doubt the efficiency of the medical care.

11. The Committee has a very high regard for the integrity, ability, efficiency and judgment of each of the members of the Illinois Public Aid Commission. We thoroughly appreciate their responsibilities. We hope that in view of the questions raised in regard to their decision that they will reconsider their problem and rescind their action in reference to the policy for medical care in the County of Cook.

12. The Committee is most grateful to Mr. Raymond Hilliard, Director of Public Aid; Miss Pearl Bierman, Medical Consultant; and Miss Marjorie Bates, Assistant Consultant, for their assistance in this program.

Respectfully submitted,
CHARLES H. PHIFER, M.D.,
*Chairman,*
EDWIN S. HAMILTON, M.D.,
JULIUS H. HESS, M.D.,
JAMES H. HUTTON, M.D.,
EVERETT P. COLEMAN, M.D.,
*Ex Officio,*
HAROLD M. CAMP, M.D.,
*Ex Officio,*
PERCY E. HOPKINS, M.D.,
*Ex Officio,*
*Advisory Committee on Medical Care of Public Assistance Recipients.*

## REPORT OF THE COMMITTEE TO STUDY PREPAYMENT PLANS FOR HOSPITAL AND MEDICAL CARE

To the Members of The House of Delegates:

This Committee appointed by the Chairman of the Council at the request of the House of Delegates of the Illinois State Medical Society in May, 1944, has continued its activities since its annual report in 1945. It has made a very exhaustive study of all the prepayment plans for hospital, medical and surgical care in the United States. It has interviewed employers of many and varied types of industrial organizations, railroad representatives, meat packers, agricultural organizations, mercantile organizations, commercial insurance carriers, representatives of large and small nongovernmental hospitals, charity hospitals, governmental and private, their types of patients, the number of annual admissions.

In our study of all the prepayment plans for medical care in the United States we inquired as to how they were organized, administered and managed, their financial structures, the categories of illness they covered, the length of time they had been operating, the number of people insured, to whom the policies were sold, the income levels if any, the fee schedules, past experiences, the advantages and disadvantages of cash indemnity and medical service plans. We met with the officers of the prepayment plans of Michigan, Indiana, Missouri, Iowa, Wisconsin, and Milwaukee.

We also investigated the state and national prepayment plans for hospital care. In doing this we interviewed representatives of all the prepayment plans for hospital care in the state of Illinois, noting particularly the length of time each plan had been in operation, what coverage their policies included, the number of policy holders, who constituted their board of directors, the cost of the policy and the amount of their reserves.

We also considered the Blue Cross Prepayment Plan for Hospital Care, its organization, activities, promotion and expansion, as well as their efforts to coordinate and include all prepayment plans for hospital care; likewise, their desire and effort to expand their activities so as to include prepayment plans for medical care. This is especially so in metropolitan areas.

The Committee after a thorough study of the comparative values of a medical service and a cash indemnity plan recommended to the Council of the Illinois State Medical Society that they endorse an indemnity type of prepayment plan for medical and surgical care to be covered by commercial insurance carriers.

The Committee drafted a set of general principles in reference to our prepayment plan which they insist all insurance carriers desiring to write this contract must accept in order to have the endorsement of the Illinois State Medical Society.

The Council endorsed the recommendation of the Committee. In order to present this report to the members of the State Medical Society, a special meeting of the House of Delegates was called on January 6, 1946. The House of Delegates endorsed the adoption of an indemnity plan as recommended by the Committee.

In the interim since then the Committee has held a number of meetings in reference to the plan. It is the opinion of the Committee that every effort should be made to put the plan into operation at once. In order to implement its activity, meetings are being held in different sections of the state to which the physicians in those councilor districts have been invited. It is hoped in this manner to speed the promotion and operation of this plan.

Respectfully submitted,
CHARLES H. PHIFER, M.D.,
*Chairman,*

EDWIN S. HAMILTON, M.D.,
FRANK DENEEN, M.D.,
ROBERT W. KEETON, M.D.,
RICHARD J. BENNETT, M.D.,
JOSEPH H. CHIVERS, M.D.,
CHARLES P. BLAIR, M.D.,
ROBERT S. BERGHOFF, M.D.,
JOHN W. NEAL,
EVERETT P. COLEMAN, M.D.,
*Ex Officio*
HAROLD M. CAMP, M.D.
*Ex Officio*
PERCY E. HOPKINS, M.D.,
*Ex Officio*
*Committee to Study Prepayment Plans for Hospital and Medical Care.*

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DR. PHIFER: Your Committee would like to submit a short supplementary report concerning the activities of the American Medical Association regarding prepayment plans for medical care and the activities of your Committee. This information was not available when our report was submitted for publication in the official 1946 Annual Reports.

When the December meeting of the House of Delegates of the American Medical Association convened, there were many resolutions presented requesting the American Medical Association to develop a national prepayment plan for medical care. These resolutions were referred to a Reference Committee of the House of which Dr. Edwin S. Hamilton was Chairman. The Committee after many hours of very careful consideration and deliberation of the question recommended to the House of Delegates that the Trustees of the American Medical Association proceed to develop a program to provide for a national prepayment plan for medical care. This recommendation was concurred in by the House of Delegates and the Trustees were charged with the responsibility.

The Trustees accordingly created a division of Prepayment Plans for Medical Care under the Council on Medical Care and Public Relations. They also provided it with a working staff to administer the activities of this Committee so as to help study, promote and develop such plans in all states.

They likewise appointed an Advisory Committee to this division. It is to be noted that after very careful study, the Council decided to form an organization to be known as the Associated Medical Care Plans. It was incorporated in 1946 under one of the not-for-profit acts of the State of Illinois. This organization will define and write the standards of approval that all prepayment plans for medical care must meet to secure the approval of the Associated Medical Care Plans of the Council on Medical Service and Public Relations of the American Medical Association. This organization will also grant the right and privilege for those prepayment plans that meet their approval to use the seal of acceptance on their stationery. A state or county plan that desires the approval of the Central Organization must meet its requirements and be in operation to receive such approval.

In the interim since your House of Delegates met on January 6th, we have held three conferences in the State of Illinois where information concerning the Illinois Plan has been made available to physicians in those Districts.

We have given a great deal of thought to promotion and publicity of the Illinois Plan. The recent restrictions on light and power as well as the trouble in printing has prevented the printing of all our publicity material. We have made an attempt however through the use of the mimeograph to have some of this material available for this meeting of the House of Delegates.

Informative data concerning our plan has been forwarded to the Council on Medical Service and Public Relations of the American Medical Association. There has been some criticism on the part of the Hospital Plans that the prepayment plan for medical care should be operated on a not-for-profit basis. The Committee is of the opinion that the question of a not-for-profit organization is not so important as long as your plan can give a broader medical coverage for less money than the not-for-profit plans offer.

The Committee sincerely hopes that in the interests of the public and the physicians the prepayment plans for hospital service in this state will cooperate with the Illinois State Medical Society in trying to help promote our indemnity plan.

We previously reported ten general principles to which we ask all insurance companies to subscribe if they desire to participate in this program and secure the endorsement of the Illinois State Medical Society. We have added two more making a total of twelve. The new principles are as follows:

K. There shall be no limitation imposed against the insured individual's right to make his own selection as to the duly licensed physician to render the medical, surgical or obstetrical service for which indemnity is provided.

L. The contracts of insurance deemed by the Committee on the Study of Prepayment Plans for Medical and Surgical Care to conform to the foregoing principles shall be approved by the Committee and no insurance contract shall be represented to have the endorsement of the Society unless the same shall first have been approved in writing by that Committee.

We are including herewith a copy of the twelve principles for the Reference Committee.

A. There shall be created and maintained by the Illinois State Medical Society a Medical Advisory Committee which will consider and rule upon controversies which may arise between or among the carriers participating in the program, the public and the medical profession.

B. Surgery in the home and office should be covered, as well as surgery in the hospital. With proper safeguards to minimize abuses, non-surgical service should be covered in hospital, home and office.

C. There should be excluded from coverage cases

where the patient is entitled to compensation under the Workmen's Compensation Act, the Industrial Diseases Act, or other similar state or federal legislation; and also excluded should be all medical, surgical and obstetrical service rendered in federal, state, county or municipal institutions in which the patient is entitled to free service.

D. There should be no provision rendering policyholder ineligible at age 65, or some other definite age, except for good cause.

E. Should policyholder leave the insured group, he should have the right, by payment of the same premium in advance, to continue the insurance for at least three months.

F. Unless the delivery fee is at least $50.00 in obstetrical cases, additional provision should be made for prenatal and postnatal care.

G. Indemnity up to $15.00 should be included to cover the cost of necessary x-ray work, either in office or hospital.

H. A reasonable indemnity should be provided to cover such costs as blood chemistry, electrocardiogram, basal metabolism, etc.

I. Exclusion should be made for the following: periodic "check-up" examinations; treatment for venereal diseases; and treatment for mental diseases rendered in an institution, but not otherwise.

J. Dependents should be limited to spouse and children, age 3 months through 18 years.

K. There shall be no limitation imposed against the insured individual's right to make his own selection as to the duly licensed physician to render the medical, surgical or obstetrical service for which indemnity is provided.

L. The contracts of insurance deemed by the Committee on the Study of Prepayment Plans for Medical and Surgical Care to conform to the foregoing principles shall be approved by the Committee and no insurance contract shall be represented to have the endorsement of the Society unless the same shall have first been approved in writing by that Committee.

The Committee has at this time approved one commercial carrier. We have at this time five other companies who desire to participate in this program.

The Committee are of the opinion that the period that has intervened since the special meeting of your House of Delegates in January has served to convince them of the soundness and desirability of a cash indemnity plan, its honesty of purpose and the minimum amount of interference in the physician-patient relationship.

Respectfully submitted,
(Signed) CHARLES H. PHIFER, Chairman

## REPORT OF THE MATERNAL WELFARE COMMITTEE

To the Members of The House of Delegates:

The Maternal Welfare Committee has met twice this year. The chairmanship of the Committee was resigned by Dr. T. B. Williamson of Mount Vernon, and Dr. F. H. Falls of Chicago was nominated to act as chairman.

At the first meeting held October 14, 1945, the Committee was told of the proposed Pepper Bill which planned an extension of the E. M. I. C. program to include anybody who wished to apply for obstetrical care regardless of their ability to pay physicians' fees, and further agreed to take complete medical care of the baby until he or she was twenty-one years old. Since the Committee did not have a copy of the bill, it was proposed to furnish each member a copy of the bill, and to call a second meeting when the members had had a chance to study the provisions of the bill and make contact with the various county chairmen in their districts and acquaint the officers of the County Societies with the provisions of the bill and their implications as applied to the practice of medicine in Illinois.

At the second meeting of the Committee held in Chicago, December 2, 1945, a full discussion was held on the bill and reports received on the attitude of the various county medical societies toward Senator Pepper's proposal. These were unanimous in condemning the bill and indicating that the physicians of Illinois wanted no part of it.

After much discussion it was decided that the Committee should poll the membership of the Illinois State Medical Society through the mail asking the following questions:

Do you care for Obstetrical Cases?

Do you favor extension of the E. M. I. C. as embodied in the Pepper Bill?

Do you feel Federal Aid is necessary to provide adequate Maternal Care in your community?

The returns on these cards were: 1,148 for obstetrical cases, and 643 did not.

1,613 did not favor extension of the E. M. I. C. as embodied in the Pepper Bill, and 299 did favor same.

1,680 did not feel Federal Aid is necessary to provide adequate Maternal Care in their community, and 166 did favor same.

The advisability of having refresher courses in the summer was discussed, and there was general agreement as to their usefulness, but some uncertainty as to whether there would be a demand because so many of the men would be taking up similar work in conjunction with other programs for the returning veteran that there would not be many who would wish to avail themselves of such a course. It was decided if there were a demand for the course as indicated at the state meeting in May, that at least one, one week course would be offered at the University of Illinois, probably in August.

It was decided to have each county chairman contact the secretary of the county medical society and try to get an obstetrical paper before each society at least once during the year.

It was considered advisable to have postmortem examinations made on as many stillborn and neonatal death babies as possible. Arrangements have been made with the pathology department of the University of Illinois to make the examinations. The matter of

transportation of the babies to the University will be taken up with the Illinois State Department of Public Health. This should increase our knowledge on the causes of fetal death in Illinois and lead to the prevention of some of them in the future. It was planned to send a report to the doctor on the case with the suggestions as to management of such cases when indicated.

The advantages were discussed of forming an Illinois State Obstetrical and Gynecological Society for the benefit primarily of the men doing the bulk of the obstetrical practice in the state (but not necessarily specializing in obstetrics). This society would form a nucleus through which programs aiming at the betterment of obstetric practice in the state could be implemented. The matter is to be further discussed and action taken at the next meeting of the Committee at the time of the annual meeting of the society.

War conditions have affected the work of this Committee as that of the Society as a whole, but with the resumption of practice by many members of the State Society and the revival of interest in the problems of private practice, your Committee hopes that more interest and enthusiasm for good prenatal, natal and postnatal care will be apparent.

F. H. FALLS, M.D.,
*Chairman.*
JOHN F. CAREY, M.D.,
*Secretary.*
A. B. OWEN, M.D.,
J. T. O'NEILL, M.D.,
W. R. YOUNG, M.D.,
R. L. IJAMS, M.D.,
M. E. BITTER, M.D.,
L. O. FRECH, M.D.,
R. E. BUCHER, M.D.,
W. C. SCRIVENER, M.D.,
*Maternal Welfare Committee.*

## REPORT OF THE COMMITTEE ON WAR PARTICIPATION

To the Members of The House of Delegates:

The work of this Committee has been very light the past year due to termination of hostilities in Europe and the Far East. They have, however, consulted several times with the Committee of Procurement and Assignment as to what further activities might be taken up by the War Participation Committee. We feel that probably this will be the final report of your Committee and wish to thank the members of the Society for assistance during the past two years.

Respectfully submitted,
E. S. HAMILTON, M.D.,
*Chairman.*
E. H. WELD, M.D.,
P. E. HOPKINS, M.D.,
G. HENRY MUNDT, M.D.,
H. M. CAMP, M.D.,
*War Participation Committee.*

## REPORT OF THE COMMITTEE ON ETHICAL RELATIONS

To the Members of The House of Delegates:

Since our last report there have been no cases referred to the Ethical Relations Committee for investigation. Accordingly, the Committee has had no stated meetings, although unofficially, they have been together a few times in the past year. They have no official report to make at this time.

Respectfully submitted,
E. S. HAMILTON, M.D.,
*Chairman.*
C. H. PHIFER, M.D.,
G. HENRY MUNDT, M.D.,
*Ethical Relations Committee*

## REPORT OF THE VETERANS' SERVICE COMMITTEE

The Veterans' Service Committee of the Illinois State Medical Society continued to maintain interest in veterans' affairs during the war. The main burden of the work was carried by veterans of World War I, who were desirous that an organization be functioning when the veterans of World War II returned.

A committee was appointed to plan the annual dinner at the 1945 session of the Illinois State Medical Society. As a result of wartime restrictions, however, the dinner and annual session were cancelled.

Early in 1946 the same committee was reappointed. A meeting was held on March 5, 1946, at the Palmer House, and the following program was arranged:

"Experiences in the North African and Italian Theatres" by Dr. Philip A. Daly, Chicago.

"Impressions Gained from Service in the Pacific Area" by Dr. James W. Sours, Peoria.

### BUSINESS SESSION

The committee discussed the advisability of developing a more definitive program that would assist the sons and daughters of veterans. After some discussion a plan to furnish financial assistance to the sons or daughters of former medical corps officers who were killed or disabled while on active military duty was favored. A tentative program has been drawn up and will be submitted to the Executive Council of the Illinois State Medical Society for consideration. If approved, the program will then be submitted to the Veterans' Service Group for its consideration.

The committee regrets the passing of Dr. Maurice L. Blatt, who for many years played an active part in the Veterans' Service Group.

Respectfully submitted,
HAROLD C. LUETH, M.D.,
*Chairman.*
P. R. BLODGETT, M.D.,
F. O. FREDRICKSON, M.D.,
T. B. WILLIAMSON, M.D.,
RALPH P. PEAIRS, M.D.,
W. C. BURKETT, M.D.,
*Veterans' Service Committee.*

## REPORT OF THE COMMITTEE ON INTERPROFESSIONAL RELATIONS

To the Members of The House of Delegates:

In deference to the demands imposed by the war and immediate postwar conditions upon your committee and members of associated professions with which your committee might be expected to cooperate, no new activities have been initiated in the past fiscal year. The only request made upon the committee came through the office of the secretary, desiring the chairman to represent the Illinois State Medical Society in a course of lecture and discussion meetings in Dental Socio-economics (The Dentist in the Social Order) presented to the dental profession and interested guests by the Chicago Dental Society and the University College of the University of Chicago. It consisted of eight meetings devoted to the discussion of basic socio-economic problems involving medical and dental care with attendance of approximately eighty to eighty-five at each meeting. The total amount of tickets sold for the series was 118. The program of these meetings accompanies this report.

It is gratifying to note the interest of the dental profession evidenced by their willingness to reserve afternoons usually given to practice or recreation and demonstrated by the registered paid attendance. Discussions of this nature cannot but improve and extend the knowledge of practitioners with respect to the health services in the fabric of society.

Respectfully submitted,

HAROLD J. NOYES, M.D.,
*Chairman.*

G. C. OTRICH, M.D.,
L. J. HUGHES, M.D.,
E. C. COOK, M.D.,
WALTER STEVENSON, M.D.,
*Committee on Interprofessional Relations.*

## REPORT OF COMMITTEE ON TUBERCULOSIS

To the Members of The House of Delegates:

The Tuberculosis Committee of your Society has been keeping itself informed on the various changes and procedures relating to the subject during the past year. Due to the uncertainties of the postwar immediate past it seemed wise not to begin work on any of the projects contemplated before the war, but rather to follow the trends as they have developed in the past and may develop in the future.

The program of establishing a Tuberculosis Committee in each County Medical Society has not been actively promoted but the time has now come to get such a program started. A few counties have such a committee and the results of their work have helped in combatting this disease. Such a committee should be formed in each county to work with the County Tuberculosis association, the Sanatorium Board if one exists, and the Health Department. Thus a close cooperation can be worked out in planning tuberculin surveys, x-ray surveys, industrial surveys, health education programs and other forms of cooperative programs. Health Education can be planned by this committee and rehabilitation work pushed with the assistance of the State Department of Public Health and the Director of Rehabilitation of the Illinois Tuberculosis Association.

A number of papers on Tuberculosis have been placed in the various section meetings at the Annual Meetings in the past and were accorded a very good reception and this plan should be followed more energetically in the future.

At least one tuberculosis program a year should be given before each County Medical Society, preferably by the Medical Director of the local sanatorium, if one is located in the County, obtaining an outstanding speaker for the program whose talk should be of interest to the general practitioner. This may be preceded or followed by a paper outlining the progress of the tuberculosis control in that particular community.

As more interest in tuberculosis control is aroused in the Illinois State Medical Society the Council should consider forming a Diseases of the Chest Section for the annual meetings at which time those interested in chest disease, tuberculosis and all other pulmonary diseases, could exchange ideas and the general practitioner could absorb practical ideas on this interesting subject.

Illinois has at present a splendid ground work laid for a comprehensive program of tuberculosis control which embraces the services of physicians, voluntary and tax supported institutions, all working with the Division of Tuberculosis Control of the State Department of Public Health. The Division has purchased portable x-ray units which can be used to find hidden cases of tuberculosis and funds will be available soon to hospitalize the patients found on survey. X-ray units have been installed in some of our general hospitals to survey all admissions and the Department of Welfare is making a study of tuberculosis in the insane and penal institutions of the state. In other parts of the state selected groups are being studied and industrial surveys are conducted. All this activity adds up to a real start on a campaign to reduce the number of unknown cases, decrease the morbidity and finally to eradicate the disease.

The family physician is still the greatest factor in all anti-tuberculosis work and his education in case finding and control is essential. Post-graduate lectures and institutes for physicians should be established with the help of the Division of Tuberculosis Control and the methods of tuberculin testing should be familiar to all family physicians, rural as well as urban.

FRED M. MEIXNER, M.D.,
*Chairman.*
HERMON H. COLE, M.D.,
FRANK J. SMEJKAL, M.D.,
*Committee on Tuberculosis Control.*

## REPORT OF THE COMMITTEE ON INDUSTRIAL HEALTH

To the Members of the House of Delegates:

During the past four years the study of "Occupational Medicine" has been advancing and extending its influence into all fields of medical practice. It is now recognized that nearly all the medical and surgical specialties as well as certain allied professional groups (engineers, chemists, nutritionists, nurses) are called upon to assume varying degrees of responsibility for the maintenance of healthy workmen employed in a healthful workshop.

Most of the surgical specialties have been making important contributions to industrial surgery. To that group has been added many of the medical specialties, such as dermatology, psychiatry, hygiene and gynecology.

Industry, organized labor and governmental agencies recognize that one of the important factors in our rehabilitation and reconversion program is a healthy attentive work force. The medical profession as a whole must assume more and more active responsibility for attaining the highest physical, mental and moral standards yet reached in every community of working people.

Your committee has been alert to the rapid growth taking place in industrial medical practice and the potential dangers of a too rapid development without guidance by medical men. There is need of a clear understanding of the scope and responsibility that can be and should be borne by the medical fraternity. There is a definite limitation of responsibility that the management of industry can assume. There is an inherent obligation on the individual which should not be misplaced.

Each member of your committee has taken an active part at meetings where the problems of industrial health and medical service in industry were under discussion. Through the cooperation of the Council of Industrial Medicine of the American Medical Association with members of your committee we have been helpful in directing and placing a number of medical officers released from the armed forces who wished to enter the field of Industrial Surgery and Occupational Medicine. The Industrial Health Section of the Illinois Medical Journal has published each month certain abstracts, articles and informative data relating to the field of Industrial Medicine.

The committee wishes to express its appreciation to the various members of the Illinois State Medical Society who have participated with us in meetings, discussions, conferences and publication of papers on special aspects of Industrial Health.

Respectfully submitted,
JOSEPH H. CHIVERS, M.D.,
*Chairman.*
F. P. HAMMOND, M.D.,
HAROLD VONACHEN, M.D.,
C. O. SAPPINGTON, M.D.,
MILTON H. KRONENBERG, M.D.,
R. I. BARICKMAN, M.D.,
*Committee on Industrial Health.*

## REPORT OF THE COMMITTEE ON VENEREAL DISEASE CONTROL

To the Members of the House of Delegates:

The Committee's chief function during the past year has been to serve in an advisory capacity. Your Chairman is pleased to report that at all times there has existed a spirit of wholesome cooperation between the Committee and Dr. G. G. Taylor, Director of the Division of Venereal Disease Control of the State Department of Public Health. There have been no changes in the policy for the prevention, treatment, or law enforcement during the last year but that the advice and sanction of the Committee has not been asked. The Committee feels that Dr. Taylor is to be highly commended for his efforts in obtaining to a high degree the active cooperation of the entire Medical Profession of the State in putting over an enlarged program in the prevention, early diagnosis, and rapid treatment of the early cases of syphilis. The appalling increased incidence of venereal diseases during the past year, as shown in the statistical report of Dr. G. G. Taylor, should be a matter of grave concern, not only to the medical profession but to the general public as well. This comprehensive report shows the tremendous amount of work which has been done through the Department and merits careful study on the basis of a public health program of communicable diseases. His report is attached to the report given by your Committee.

Respectfully submitted,
I. H. NEECE, M.D.,
*Chairman.*
HARLAN ENGLISH, M.D.,
BUDD C. CORBUS, M.D.,
*Committee on Venereal Disease Control.*

### REPORTING OF VENEREAL DISEASES

In 1945, 49,622 cases of venereal disease were reported in Illinois; 17,406 (34.4 per cent) of these were reported by private physicians, 32,576 (65.6 per cent) by clinics, hospitals and other institutions.

### VENEREAL DISEASE CASES REPORTED IN ILLINOIS, 1945

| *Disease* | *Total Cases Reported* | *Private Physicians* | *Clinics, Hospitals and other Institutions* |
|---|---|---|---|
| Syphilis | 21,675 | 10,689 | 10,986 |
| Gonorrhea | 27,117 | 6,331 | 20,786 |
| Chancroid | 587 | 20 | 567 |
| Granuloma Inguinale | 34 | 4 | 30 |
| Lymphogranuloma Venereum | 209 | 2 | 207 |
| Total | 48,622 | 17,046 | 32,576 |
| Percent | 100.0 | 34.4 | 65.6 |

Syphilis reports numbering 21,675 were tabulated by stage in the following manner:

SYPHILIS CASES REPORTED IN ILLINOIS, 1945

| *Stage of Syphilis* | *Number Reported* | *Percentage Reported* |
|---|---|---|
| Primary | 1,621 | 7.5 |
| Secondary | 2,511 | 11.6 |
| Early Latent | 5,422 | 25.0 |
| Late Latent | 9,566 | 44.1 |
| Cardiovascular | 375 | 1.7 |
| Central Nervous System | 1,377 | 6.4 |
| Other Late | 222 | 1.0 |
| Congenital | 581 | 2.7 |
| Total | 21,675 | 100.0 |

## STATE LABORATORY EXAMINATIONS

During 1945, the following laboratory examinations for syphilis and gonorrhea were done by the Illinois Department of Public Health Laboratories, Chicago Board of Health Laboratories, other municipal laboratories, private and hospital laboratories in Illinois:

A. Syphilis—

1. Blood Tests—1,048,403.
2. Spinal Fluid Examinations—13,635.
3. Darkfield Examinations—15,487.

B. Gonorrhea—

1. Smears—311,140.
2. Cultures—109,268.

Premarital Blood Tests: In accordance with the Illinois premarital examination law, during 1945, there were 123,305 blood tests done, of which 3,201 were positive, (2.6 per cent).

Prenatal Blood Tests: In accordance with the Illinois prenatal examination law, during 1945, there were 82,534 blood tests done, of which 963 were positive, (1.2 per cent).

## INVESTIGATIONS OF DISCHARGED MILITARY PERSONNEL

In accordance with the policy of assisting in every possible way toward the rehabilitation of demobilized military personnel, the Division of Venereal Disease Control undertook the responsibility of seeing that complete treatment facilities were made available, free of charge, to any veteran infected with venereal disease.

In line with this policy, 1,893 separatees living in downstate Illinois with either a previous history of syphilis or with positive or doubtful serologies at separation from the Armed Forces were investigated for diagnosis and treatment.

For all types of investigations based on previous syphilitic history and present serologies, 62 per cent of these investigations were completed during 1945; of those investigations completed, 85 per cent of the separatees were located and examined.

For that group of separatees with previous histories of syphilis based upon completed investigations, 31 per cent were placed under treatment; 55 per cent were considered to have had previous adequate treatment; the remaining 14 per cent were not examined by reason of being unable to locate or uncooperative.

For those with no previous history of syphilis, but with a positive serology on separation from miltary service, completed investigations found that 64 per cent were not infected on subsequent examinations; 22 per cent were placed under treatment, observation, or were found to have had adequate treatment previously; the remaining 14 per cent were not located or uncooperative for examination.

For those with no previous history of syphilis but with a doubtful serology on separation from military service, completed investigations found 75 per cent to be not infected; 4 per cent were under treatment, observation, or were found to have had adequate treatment previously; the remaining 21 per cent were not located or uncooperative for examination.

## EPIDEMIOLOGY

The success of the control of syphilis and gonorrhea depends very largely upon the careful tracing of every infection to its original source and the investigation of every person whom the patient might have exposed.

The following table presents the results of 8,124 completed contact investigations made during 1945. These contacts were named on military contact referral forms, morbidity reports, interstate referral forms, and correspondence for follow-up.

ANALYSIS OF COMPLETED INVESTIGATIONS OF CONTACTS (NAME GIVEN) 1945

| *Results on Investigations* | *Number* | *Percent* |
|---|---|---|
| Examined not infected | 2,259 | 27.8 |
| Under treatment | 1,824 | 22.4 |
| Adequate previous treatment | 64 | 0.8 |
| Unable to locate | 1,448 | 17.8 |
| Moved out of jurisdiction | 613 | 7.5 |
| Inducted into armed services | 43 | 0.6 |
| Patient uncooperative | 121 | 1.5 |
| Information insufficient for follow-up | 1,569 | 19.3 |
| Other dispositions | 183 | 3.4 |
| Total | 8,124 | 100.0 |

## TREATMENT PROVISIONS

Treatment facilities for the medical care of indigent infectious venereal disease cases are provided by venereal disease clinics, private hospitals, State hospitals and private physicians.

A. Venereal Disease Clinics—

In 34 downstate Illinois clinics there was a monthly average case load of 3,135 syphilis patients for 1945.

B. Private Hospitals for Rapid Treatment—

Since November 1, 1945 there have been established at strategic points in downstate Illinois, where laboratory service and local hospital beds are available, local facilities for rapid treatment using the recommended routine of 1,200,000 units of penicillin, 5 arsenicals and 3 bismuth injections, in a 5 day period, for the treatment of primary and secondary syphilis. Local hospitals in Bloomington, Cairo, Canton, Champaign, Danville, Decatur, Galesburg, Herrin, Kankakee, LaSalle, Mattoon, Peoria, McLeansboro, Peru, Quincy, Rockford, Salem and Springfield have been contacted as facilities for rapid treatment. In an area of approximately 50-mile radius around Chicago and around St. Louis, the rapid treatment facilities of the Chicago

Intensive Treatment Center and the Midwestern Medical Center will be used respectively.

In areas surrounding rapid treatment facilities in private hospitals, physicians who refer a suspected primary or secondary case for confirmation of diagnosis and rapid treatment will be paid a reasonable fee ($10.00) for such service, provided this feature is endorsed by the County Medical Society.

If the diagnosis is not confirmed, or if patient elects to return to the physician for treatment, no fee will be paid. If, however, the diagnosis is not confirmed by darkfield examination, but the patient is again referred because of a positive blood during the ensuing 8 weeks, the case will be admitted for rapid treatment and the fee paid to the referring physician.

This proposed program has been approved by the Venereal Disease Committee of the State Medical Society and has been submitted to the local society in any county before a referral fee is paid.

As of December 31, 1945, 40 primary and secondary patients have utilized these rapid treatment facilities. As of March 29, 1946, approximately 150 of such patients have used these facilities.

C. State Hospitals—

Five State hospitals have been designated as quarantine hospitals for the isolation, treatment and diagnostic facilities for patients found infected or suspected of being infected with a venereal disease. This function was discontinued November 1, 1945 when private hospitals took over this activity.

Nine State hospitals have been designated to hospitalize positive spinal fluid cases for fever therapy.

During 1945, 103 positive spinal fluid cases were hospitalized for fever therapy, and 304 cases were hospitalized for quarantine and treatment.

D. Private Physicians—

Treatment facilities have been provided for in those cities where no clinic has been established, as well as in sparsely populated areas too far distant from a venereal disease clinic or state institution, by paying private physicians $2.00 per treatment for the care of venereal disease cases referred to them. For such cases in 1945, $2,844.12 was paid out to private physicians.

## REVISED RULES AND REGULATIONS

On January 1, 1945, the Revised Rules and Regulations and Supplementary Information for the Control of Venereal Diseases were published. Valuable assistance was given in the preparation of this manual by the Illinois State Medical Society, District No. 3 office of the U. S. Public Health Service, Office of the Attorney General, the Office of Community War Services and several health officers of Illinois cities and counties.

The Division of Venereal Disease Control is appreciative of the interest manifested and helpful suggestions made by the members of the Venereal Disease Committee of the Illinois State Medical Society.

## REPORT OF COMMITTEE ON CANCER CONTROL

To the Members of The House of Delegates:

This Committee is pleased to submit the following report of its activties for the years 1945-1946.

As has been the case in the past, the chief function of this Committee is to advise on matters concerning cancer to all agencies and organizations throughout the state and we can report that there exists a spirit of cooperation between this Committee and all organizations concerned with cancer, its diagnosis and treatment. It has become increasingly evident that it is important that every effort be made to satisfy the expressed demands of an intelligent and aroused public as well as the medical profession. It is equally important that the public be protected against the overzealousness of social reformers and misinformed enthusiasts. This is and has been our task.

The Advisory Committee of the Division of Cancer Control of the Department of Public Health of the State of Illinois has been active throughout the year and members of this Advisory Board have devoted a great deal of time to matters concerning the promotion of an intelligent cancer control program, have made visits to institutions in various parts of the United States to investigate cancer hospitals and control programs. This Advisory Board has been in close contact with the Director of the Department of Public Health who has shown an earnest interest in the promotion of the cancer program. Three tumor diagnostic services have been established downstate and functioning in Rockford, Springfield, and Champaign and a new one has recently been started at East St. Louis. Several more diagnostic services are contemplated and it is urged that the medical profession throughout the state utilize these facilities more freely. Information concerning them can be procured by writing to the Division of Cancer Control, Illinois State Department of Health, Springfield, Illinois. During the year the Division of Cancer Control has given aid to the Tumor Clinic at the Illinois Research Hospital in Chicago.

During the last session of the Legislature, House Bill No. 191 was introduced into the Legislature relative to the construction of a State Cancer Hospital. This was an ill-conceived bill to appropriate a million dollars to build a State Cancer Hospital to be operated by the Department of Public Welfare. Its provisions were not very well thought out but it may well be considered an expression of the demand on the part of the public for specific and skilled care of cancer patients. Such projects must always be considered seriously. This bill died in committee but there is no question but what increasing pressure along this line will be made upon the Department of Health in ensuing legislative sessions and the demand will have to be met. It is the intention of this Advisory Board and your Cancer Committee to steer the demand into the proper channels.

The Chicago Cancer Society Committee, Inc. dur-

ing the past year has been absorbed by the Illinois division of the American Cancer Society. Certain activities of the Chicago Cancer Society have now been taken over by the Illinois Division of the American Cancer Society and the Executive Committee of this Illinois Division made up largely of members of the Cancer Committee of the Illinois State Medical Society. This Executive Committee together with a much larger Medical Advisory Committee is getting under way and the Illinois Division, American Cancer Society will be a potent force in cancer affairs in the state during this coming year.

The American Cancer Society, Illinois Division, this past year, became a part of a national drive for funds during the past year. This drive under the National Chairmanship of Mr. Eric Johnston at that time President of the United States Chamber of Commerce and Mr. Charles Glore, for the State of Illinois, met with considerable success, considering the limited amount of time available for preparing for this campaign for funds. As a result of this fund raising campaign, $109,000.00 was raised in the State of Illinois. About $60,000.00 is to be spent in Illinois. The Executive Committee of the Illinois Division, American Cancer Society aided by the larger Medical Advisory Committee is planning a program and activities are already under way and will be provided for. New projects, both professional and lay educational, will soon be undertaken. The Field Army under the direction of Mrs. Arthur I. Edison, who has devoted a tremendous amount of time and effort to the work has been active in lay and student education, formation of surgical dressing units and assisting in the Cancer Prevention Clinic at the Women's and Children's Hospital in Chicago. Plans for programs of student education are progressing favorably and it is believed that soon the fundamental and basic principles of cancer can be presented to the students in high schools and junior colleges and through these young students information can be carried home to the adult members of their families. The Department of Public Health is assisting in this work.

The Cancer Prevention Clinic at the Women's and Children's Hospital is now in operation two evenings a week and the demand for examinations has been so great that appointments are booked several months in advance. The work of this Clinic under the direction of Dr. Augusta Webster was reported in the April number of the Illinois Medical Journal. Much material is being made available for students and this information, within the next few years, will be valuable in determining the exact importance of such examinations. This clinic deserves the whole-hearted approval and confidence of the medical profession and this committee can vouch for the honesty and unselfishness of the members of the Staff of this Clinic.

In the report of this Committee in May, 1944, the following statement was made:

"Your Committee is definitely of the opinion that cancer control has gained a very definite foothold and it will be one of the foremost programs before the public in the coming years. There is no question that social service agencies recognize this fact and are ready to step in and institute their programs unless the medical profession handles the situation efficiently. Likewise, unless the medical profession exerts itself to provide adequate diagnosis and therapeutic facilities, the public will demand it from the state."

Bills will continue to be introduced into the Illinois Legislature asking and demanding that more be done for the cancer patient. The medical profession cannot stand idly by and oppose these projects and offer nothing constructive in lieu thereof. The medical profession with the cooperation of prominent lay citizens must direct and lead these activities. This we are trying to do.

This Committee wishes to thank the Division of Cancer of the Illinois State Medical Society for its continued interest in the work of this Committee. This Committee also wishes to thank Miss McArthur of the Educational Committee of the Illinois State Medical Society for her sincere and active assistance.

Respectfully submitted,
JOHN A. WOLFER, M.D.,
*Chairman.*
BOWMAN C. CROWELL, M.D.,
J. P. SIMONDS, M.D.,
ANDY HALL, M.D.,
ROSWELL T. PETTIT, M.D.,
CHARLES L. LEONARD, M.D.,
JOSIAH J. MOORE, M.D.,
HARRY OTTEN, M.D.,
*Committee on Cancer Control.*

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This report was written by Roswell T. Pettit, M.D., at the request of Harold M. Camp, M.D., Secretary of the Illinois State Medical Society, due to the illness of Dr. John A. Wolfer, Chairman.

## REPORT OF THE FIFTY YEAR CLUB COMMITTEE

To the Members of the House of Delegates:

In January, 1938, the Council of the Illinois State Medical Society, realizing that many physicians in the state had been practicing medicine for fifty years or more, and wishing to do them just honor, organized the Fifty Year Club. The Club is a phantom organization, without officers, dues, or meetings. Those physicians, whether a member of the Society or not, who have been in the practice of medicine for fifty years or more, and are so recommended by their county society, are eligible to membership.

County societies throughout the state have been holding special meetings to honor these "grand old men of medicine," and the State Society Committee sends a lapel button and a framed certificate of membership for presentation.

We recommend that the county medical society in which the members reside should always sponsor the meeting in which these honors are conferred, unless they combine with some adjoining county medical society.

. Since the annual meeting last year in Chicago, the following changes in membership have taken place:

Chicago:

| | |
|---|---|
| Membership May 1, 1945 | 117 |
| Deceased during 1945-1946 | 5 |
| New members during 1945-1946 | 26 |
| Membership, May 1, 1946 | 138 |

Downstate:

| | |
|---|---|
| Membership May 1, 1945 | 95 |
| Deceased during 1945-1946 | 12 |
| | 83 |
| New Members during 1945-1946 | 9 |
| Membership May 1, 1946 | 92 |
| Total Club Membership, May 1, 1946 | 230 |

It has come to my knowledge that there are a number of physicians throughout the state, who are eligible for membership, who have not been so honored. They are men who have dropped out of practice and are not active in Society work who have been forgotten or neglected by the officers of the societies in the counties in which they reside. There are other physicians who are entitled to this honor who are yet actively engaged in the practice of medicine.

It is not possible to give an accurate number of the physicians who are now members of the Fifty Year Club as the mortality of these men is quite high and the deaths of many are not promptly reported to the Secretary of the State Society. But to the best of my knowledge, the membership does not exceed 240. As there are approximately 12,000 physicians in the state, it is apparent that the Fifty Year Club is a very exclusive club.

Five years ago invitations were sent to every member of the Fifty Year Club to attend a noonday luncheon during the State Medical Meeting. Since that time it has become an annual affair. Two years ago seventy members of the Fifty Year Club were present at the luncheon. Considering the fact that most of these members were past seventy-five years of age and the membership does not exceed 240, there was a remarkable percentage of membership present.

Now that the war is ended and the young men are returning home, many of us hope to and will retire.

Respectfully submitted,
ANDY HALL, M.D.,
*Chairman.*
C. E. WILKINSON, M.D.,
E. H. OCHSNER, M.D.,
H. O. MUNSON, M.D.,
*Fifty Year Club Committee.*

## REPORT OF COMMITTEE ON MEDICAL ECONOMICS

To the Members of the House of Delegates:

The Committee on Medical Economics has had as its chief responsibility during the past year the preparation of articles on topics of economic interest to the profession in our State Journal. These topics included an analysis of the Beveridge report which covers the current medical controversy now active in England concerning socialization of the medical system. Other topics were our own Wagner-Murray-Dingell Bill now under discussion in the Congressional Committee, and other subjects concerned with medical practice within the state. One paper was an excellent description of the County Poor Farms throughout the State of Illinois.

The committee will meet again during the Illinois State Medical Society Meeting to discuss the program for the material for the State Journal during the coming year. Another subject on the agenda is consideration of the assumption of other responsibilities of economic interest to the Society.

The Chairman would also like to take this occasion to formally thank all the members of the Committee for their helpful and critical advice on the material submitted to the Journal.

CHAUNCEY C. MAHER, M.D.,
*Chairman.*
E. S. HAMILTON, M.D.,
V. THOMAS AUSTIN, M.D.,
EMMET B. BAY, M.D.,
JAY McDONALD MILLIGAN, M.D.,
GEORGE HALPERIN, M.D.,
MARIE WESSELS, M.D.,
THOMAS C. BROWN, M.D.,
ROLAND R. CROSS, M.D.,
MILTON E. BITTER, M.D.,
EDWIN F. HIRSCH, M.D.,
FORD K. HICK, M.D.,
WILLIAM J. BRYAN, M.D.,
JOHN VONACHEN, M.D.,
HARRY A. OBERHELMAN, M.D.,
*Committee on Medical Economics.*

## REPORT OF COMMITTEE ON RURAL MEDICAL SERVICE

To the Members of the House of Delegates:

The President, Dr. E. P. Coleman, G. C. Otrich and myself represented the State of Illinois at the first annual conference on Rural Health, March 30, 1946, at the Palmer House.

Dr. F. S. Crockett, chairman, related the purpose of the conference. Dr. Olin West made a few remarks. Mr. Ranson Aldrich of Mississippi, discussed the Farm Medical Care Program. It was his impression that some of the fees charged by the profession were too high and be cited as an example, the old $1 a mile fee for consultation, which had not been changed since the advent of good roads and transportation. Speaking for his part of the country, he felt that perhaps federally built, but locally supported health centers would be the best answer for the country's medical problem, if these health centers were well located and properly equipped. Dr. Leonard Larson from North Dakota, cited reasons

why the Hill-Burton Hospital Construction Bill would work out if the rural people and the profession would locate these health centers in a *proper* area. He very strongly opposed some of the current fund raising activities on the part of the rural areas in trying to build hospitals that can never be maintained and are far beyond the local needs.

Dr. Fred R. Mott, U. S. Federal Health Service, cited a number of statistics as to why Mr. Truman's Health Bill had to be passed before the rural areas would have any medical care. He came all out for a compulsory tax and promised everything. His remarks were about as popular with the audience as a garlic eater would be at a post-office game.

Dr. Victor Johnson, in discussing his paper, stated that he had only 20 minutes to read the paper and it made the discussion difficult, but he pointed out several reasons as to why a compulsory program would end up with *deterioration* of the *quality* of the medical care, medical education and of the people's general well-being.

Mr. Howard Strong, of the U. S. Chamber of Commerce, stated that that body had stayed away from the Compulsory Health Program but still felt there were local areas in the country where the economic status of the people was such that they needed some assistance. The Chamber proposed that the Federal Government construct the necessary facilities in those areas but leave the maintenance of them entirely to the local areas to support, probably by some type of local taxation.

Dr. Leland Tate of the Farm Foundation, discussed some techniques by which the rural population could be educated toward using existing facilities as well as not getting too ambitious in constructing their own facilities.

The fireworks were really exploded by Mrs. Charles Sewel of the Associated Women of the Farm Bureau Federation. Her remarks were particularly down to earth and she told of many incidents that have happened in our national government set-up which proved that a central government bureau cannot do a satisfactory job of providing personalized service to rural people. Speaking for the Farm Women, she wanted *cooperation* and *not compulsion.*

At the luncheon meeting, Honorable Percy Priest, Congressman from Tennessee, told of his experiences with the current health legislation. He and a great majority of Congress are pushing the Hill-Burton Hospital Construction Bill. He said the hearings on the Wagner-Murray-Dingell Bill would probably run from 8 to 10 weeks and unless all sides were heard and agree on amendments, even if passed, it would be unworkable. It was his considered opinion that the people in certain areas are in need of a better type and better availability of medical care and that the government, federal and local, as well as the profession would have to provide this improved type of care some way. He doubted that compulsion would be the answer except in isolated instances.

During the afternoon, representatives from various states were heard from, as to what they were doing in the rural health field. Some states are far along with the program and others are not. In general, the representatives from the predominant agricultural states did not agree with Dr. Mott that the farmer's average income was anywhere near the figure he cited. They also seriously questioned the federal government's ability to compel the farmers to accept a tax for so-called complete medical coverage. So far as Illinois is concerned, we reported that our committee was new but we hoped that in each rural county society in the next year, a meeting of the doctors and the farm leaders would be held to discuss the medical and hospital problem in their individual areas.

Dean H. P. Rusk, of the University of Illinois College of Agriculture, and the heads of Farm Bureau and other farm organizations as well as Dr. Cross, are being consulted and a coordinated approach to the problem will be developed.

HARLAN ENGLISH, M.D.,
*Chairman.*
G. C. OTRICH, M.D.,
W. I. LEWIS, M.D.,
E. C. COOK, M.D.,
J. C. REDINGTON, M.D.,
*Committee on Rural Medical Service.*

## REPORT OF THE WOMAN'S AUXILIARY

To the Members of the House of Delegates:

As President of the Woman's Auxiliary to the Illinois State Medical Society, I wish to present the following report:

1. MEETINGS:

As there was no House of Delegates meeting in 1944-1945, it was necessary to hold a special Board meeting in May 1945, to formulate plans for the coming year. Regular Board meetings were held in November and in March. Plans for the Convention to be held in Chicago at the Congress Hotel May 14 and 15 call for a pre-convention and a post-convention Board meeting.

2. OFFICERS:

The same group of officers and chairmen served from 1944 until 1946 as there is no provision for an election without a meeting of the House of Delegates. These women carried on cheerfully and efficiently, feeling it a responsibility to continue this work which is so closely associated with their husbands' profession.

3. ORGANIZATION AND MEMBERSHIP:

The sixteen county auxiliaries have remained intact during the war years. Although it was impossible to add any new counties in the past few years, there are indications that there are some counties which now wish to organize. The work in this department will be intensified this coming year.

The membership this year is officially 887. This shows a drop of about a hundred from last year, although there has been an increase in some individual counties. This is explained by the fact that several component auxiliaries who had been paying State and Na-

tional dues for service wives were unable to do so this year. These members were carried locally, however, and as their husbands return to civilian practice will gradually assume their own obligations again.

4. BENEVOLENCE:

The Auxiliary is very proud to announce that the treasurer has sent in $1,844.27 as of April 19. It is hoped that this may reach the two thousand mark by the end of the annual year in May.

5. PUBLIC RELATIONS:

The advice of the Advisory Committee of the Illinois State Medical Society was followed in the developing and maintaining liaison contacts with other organizations. Public Relations programs were held by most counties with speakers on current medical legislation. In most cases these proved successful and showed an increase over previous years in the interest of the public.

6. LEGISLATION:

The work of all departments of the Auxiliary was actively carried on by the various chairmen, but much concentration was put into legislation. An intensive campaign was brought to all members so that they would be well informed on current medical legislation. This obtained very satisfying results, as a number of our wives were able to discuss this subject intelligently and convincingly when it came up in other organizations to which they belong.

All members were urged to write their senators and representatives as individuals concerning the Wagner-Murray-Dingell Bill. Many such letters were sent to Washington and a number of replies were received most of which were very non-committal.

Delegates to the National Convention of the Y. W. C. A. were contacted and packets of material from the National Physicians' Committee were supplied. Plans are for the covering of delegates to all large national women's organizations' meetings wherever possible.

The value of the Auxiliary in this legislative field was expressed by the House of Delegates of the A. M. A. in a resolution passed in Chicago in December.

"Whereas, The object of the Woman's Auxiliary is to aid the American Medical Association in every way requested: and

"Whereas, The most urgent need at the present time is for wide spread dissemination of knowledge concerning the hazards of current medical legislation; therefore be it

"Resolved, That the House of Delegates of the American Medical Association request the Woman's Auxiliary to use every avenue possible to bring this information to its members and through them to the public."

7. HYGEIA:

The greatest effort put into health education by the Auxiliary is through the sale and distribution of Hygeia. This magazine is placed in schools, libraries, hospitals, and many other public places.

8. SCHOOL OF INSTRUCTION:

For the second year there were two Schools of Instruction held in the state. They were in Chicago and in Springfield. The reason for the Schools is to inform new officers and chairmen of their duties and to familiarize them with the mechanics of the organization.

9. AS PRESIDENT:

In my two years of office I have visited the following counties at least once and in most cases twice. This includes Bureau, Logan, Sangamon, Henry, St. Clair, Cook, Peoria, Marion-Clinton, and Vermilion. Conflicting dates prevented the acceptance of several other invitations.

In December I attended the second National Conference of the Auxiliary to the American Medical Association and reported for Illinois. This Conference is composed of State presidents, state presidents-elect and the chairmen of standing committees. The interchange of ideas and discussion of problems tends to give a more cooperative and closely knit organization.

All chairmen were given instruction as to their work and a close personal contact maintained. County presidents were invited to meetings in order that they might become acquainted not only with the work, but also, with each other.

The encouragement and cooperation of the Advisory Committee of the Illinois State Medical Society has meant much to the progress of the Auxiliary. This Committee is made up of Dr. Frank P. Hammond, chairman; Dr. R. K. Packard; Dr. S. E. Munson; and Dr. Harold Camp. Our deepest thanks go to these men for their guidance and courtesy.

The Auxiliary wishes to say as always that it remains willing to assume any task which the Medical Society may lay out.

Respectfully submitted,
ESTELLA GAREISS,
(Mrs. Alfred F.)
*President, Woman's Auxiliary.*

## REPORT OF THE EDITOR

To the Members of the House of Delegates:

Although the war is over, the Illinois Medical Journal is not as yet back to normalcy in many respects. Throughout the war with paper and labor shortage we had to be tolerant more than ever before when there was an unusual delay each month in getting the Journal into the mail. We did send a copy each month to every member in service, this requiring considerable effort on the part of our Business Manager, who personally had to go to the Post Office and submit a list of those to receive the Journal in all parts of the world, and show the necessity for mailing these copies to the service men, and this had to be done each month.

We received many complaints from medical officers, who frequently reported receiving a Journal, then a delay of several months, when several copies would arrive in the same mail. Not being sent by first class mail this, of course, was a circumstance beyond our control. Frequently upon receipt of a request, we sent single copies as desired, by first class mail to reach the member-officer in the shortest possible time.

During the war, as we have previously reported, the

printers were working overtime with a reduced personnel, and did the printing on presses which were gradually deteriorating, and there was no chance for replacement. We were restricted in the use of paper, but fortunately early in the conflict we were using paper which had been bought and paid for in advance, and credited against our acocunt as it was used. Consequently there was but little appreciable reduction in the size of the Journal most of the time.

With the ever-increasing requests for permission to advertise in the Illinois Medical Journal, our committees have been more critical in their accecptance of new contracts. The Journal Committee and Editorial Board have held joint meetings, at which many matters concerning the Journal have been carefully considered. We have been most fortunate in receiving many scientific articles and short case reports during the past year, for with the cancelation of the annual meeting in 1945, this would have been a serious problem otherwise. The majority of the papers submitted for publication have been referred to the Editorial Board before final acceptance was announced, and we believe this is an important function which should be encouraged in the future.

Some new departments have been added during the interim since the last annual meeting. The physical therapy abstracts under supervision of Dr. John S. Coulter have been of much interest to many of our subscribers, and some commendatory letters concerning them have been received. After an absence of a year or more, the committee on Medical Economics has resumed the use of their department, and it is hoped that these articles on timely economic subjects will continue regularly. The Journal force has been pleased with the number of papers and case reports which were received from men in service, many of these being of unusual interest to the readers of the Journal. The handicaps under which many of these articles were written will never be known to any, except the writer. One writer related that he was writing in a dug-out, which was also occupied by a six-foot, but harmless, snake, and at the same time a four-inch ant was trying to carry off one of the pages he had finished.

During the past year we could have easily each month used all available space in the Journal for advertisements, but even though all of them could have been ethical concerns and products, it is not the desire of this Society to publish a Journal for revenue primarily, and it was the desire of the Journal force to continue carrying in each issue, the usual number of scientific articles, maintain the several departments, and do everything possible to continue making ours look like a medical journal.

It seems quite probable that within a few months the Illinois Medical Journal will be coming off the press and release through the mail on the old pre-war schedule. Many letters have been received from members, as well as other subscibers, stating that they failed to get their Journal and giving the information that they look forward each month for the opportunity of looking it over, as some say, "from cover to cover." Then we learn upon investigation that they have not received the current issue for the same reason that some 9,500 others have not received it, and have notified the writers to be patient a little longer and it would be forthcoming. It is indeed a pleasure on the part of the Journal force to know that their efforts are appreciated. Some interesting stories were received during the past year from members overseas, who wrote that their Journal was the only medical publication which had been received at their base during the month, and that it went from one to another of the medical personnel stationed there, until it was almost worn out.

In the "News of the State" section you will note the enlargement during the past year, as it was deemed advisable on the part of the Editorial Board to urge county medical society secretaries to send in news notes, information relative to their meetings, and other information which would be of interest to many of their members. Likewise these county society officers were asked to report immediately on the return of medical officers separated from service, as this is always news to many physicians, many times far away from the individual counties.

Once more we would recommend to the many hundreds of Illinois physicians who served with the armed forces, most of them stationed in various parts of the world, that they write articles on medical problems encountered, elaborate on cases of an unusual nature which were under their care, or something about the countries where they were stationed, as articles along these lines would be of much interest and value to physicians everywhere who remained at home to carry on in civilian practice throughout the recent conflict. Now that the war is ended, they are privileged to write many things which previously could not be recorded.

We also want to call to the attention of the former medical officers the fact that the Illinois State Medical Society is accumulating photographs and biographic data concerning all members. For the past three years our official photographer has been present at the annual meetings, regional meetings, and has spent much time touring the state to take pictures of members of this Society at no expense to the individual members, unless they voluntarily desire additional photographs. One finished copy is given to the Society for the Archives. As has been reported elsewhere in this handbook, Dr. Carl E. Black, who passed away on January 13, had been intensely interested in this work as a hobby over a period of many years. His large collection of photographs of physicians, including many of the pioneers of Illinois, has been turned over to this Society, and is now safely stored permanently in the building of the Illinois State Historical Society at Springfield. As photographs are received, they are mounted, indexed and added to this collection, and this will be a function of the Committee on Archives in years to come.

At this time your Editor once more wishes to thank the Managing Editor, who has worked so faithfully and effectively for the interests of the Journal, the Editorial Board for its interest and decisions, the Journal Committee which has had many problems placed before it during the past year, and for the suggestions and criti-

cisms which have been received from many members of this Society. Suggestions for the improvement of the Journal are always solicited and appreciated, and it is the desire of those responsible for the publication each month of the Journal to do everything possible to improve Your Medical Journal.

Respectfully submitted,
HAROLD M. CAMP, M.D.,
*Editor.*

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DR. CAMP: Dr. Hall called attention to an error in the Handbook. I want to say a word in defense of the printer. We have usually sent the Handbooks to the members of the House of Delegates two weeks in advance. Then Mr. Lewis came along and our printer worked but four hours a day by power and the rest of the time by candle light. He worked all Saturday night, all day Sunday and Sunday night trying to get our programs and handbooks out. That is the reason you did not get it in advance. Although we tried to proof this by candle light, probably a few errors have crept in.

Regarding the President's address, announcement of it was omitted from the program. Dr. Coleman will give his address tomorrow afternoon at 1:30 P.M. in the Grand Ballroom.

THE PRESIDENT: The Secretary tells me there is no unfinished business so we will pass to new business, and the first item under this heading is the introduction of resolutions and referral to the Resolutions of the Committee. Will the Chairman of the Resolutions Committee, Dr. Pfeiffenberger, come forward to receive the resolutions.

DR. ANDY HALL: I wish to present the following resolution:

1. *Licensing of Physicians from Unapproved Medical Schools.*

*Whereas,* the State Board number of the Journal of the American Medical Association in the issue of May 11, records that, during the past six years Illinois has licensed 367 physicians from unapproved medical schools, and with the exception of Massachusetts, all the other states in the union licensed only 81, and

*Whereas,* it further states that, in 1945, Illinois licensed 115 from unapproved medical schools, and with the exception of Massachusetts, which licensed 38, and Virginia 3, no other state in the union licensed a single physician from an unapproved medical school, and

*Whereas,* the record shows that many from other states who are unable to obtain licenses in their own state are being licensed and locating in Illinois, where the requirements are below standard, therefore be it

*Resolved,* that, we appeal to the Governor of Illinois, the Director of Education and Registration, the Board of Medical Examiners and the members of the Legislature that they promulgate such rules and enact such laws as will be in keeping with those of our surrounding states.

DR. A. H. BITTER, Quincy. I wish to introduce the following resolution from the Adams County Medical Society.

2. *Objection to Inclusion of Physicians' Services in the Central Illinois Hospital Service Association.*

*Whereas,* the membership of the Illinois State Medical Society is alarmed at the advances being made by various Blue Cross Hospitalization Insurance Plans to include certain types of medical service in their insurance coverage, and

*Whereas,* the Adams County Medical Society recently withdrew its approval of the Blue Cross Plan serving part of central and western Illinois because it was including medical services in its insurance coverage, and

*Whereas,* The American Medical Association, the Illinois State Medical Society, the Chicago Medical Society and numerous other medical organizations have consistently opposed the inclusion of medical services in the benefits which hospitals guarantee to furnish Blue Cross subscribers, expressly referring to anesthesiology, pathology and radiology as medical services which can legally be rendered only by licensed physicians, and

*Whereas,* the inclusion of some medical services among Blue Cross benefits at this time will complicate and confuse the situation now that a prepayment insurance plan for medical care sponsored and approved by the Illinois State Medical Society has already been placed in operation, and

*Whereas,* the surrender of control over any part of the practice of medicine to lay agencies such as the Blue Cross would, in many respects, be equally deleterious to medical practice as proposals for government regimentation of medicine which is so strenuously opposed by the medical profession, and

*Whereas,* the Central Illinois Hospital Service Association, the Blue Cross Plan serving part of central and western Illinois, has recently included certain medical services in its insurance coverage, therefore be it

*Resolved,* that the Illinois State Medical Society voice its protest to the inconsiderate action on the part of the Central Illinois Hospital Service Association, in adding the service of physicians to the benefits furnished by hospitals without seeking or receiving the approval of the physicians concerned or the Illinois State Medical Society, and be it

*Resolved,* that the Illinois State Medical Society withdraw approval of the Central Illinois Hospital Service Association and refuse to lend support to its Blue Cross Plan as evidence of objection to the inclusion of physicians' services in Blue Cross benefits in direct violation of the principles of the American Medical Association and contrary to the expressed purpose and scope of the Blue Cross group hospitalization plan, and be it further

*Resolved,* that copies of these resolutions be sent to the Illinois Hospital Association, to the officers and directors of the Central Illinois Hospital Service Association, to the Superintendents and Trustees of all the Hospitals and the Secretaries of all the County

Medical Societies served by this organization, with the request that they continue to cooperate with organized medicine in its endeavors to protect the practice of medicine from the control or domination of any corporate, lay or government agency, outside the organized medical profession.

DR. FRANK P. HAMMOND, Chicago: I wish to present the following resolution.

3. *Dissemination of Knowledge Concerning the Hazards of Current Medical Legislation Affecting the Private Practice of Medicine Through the Efforts of the Woman's Auxiliary.*

*Whereas,* the objective of the Woman's Auxiliary is to aid the Illinois State Medical Society, and through it, in conjunction with the National Auxiliary, the American Medical Association, in every way deemed wise and concurred in by the Advisory Committee, and

*Whereas,* the most urgent need at the present time is for widespread dissemination of knowledge concerning the hazards of current medical legislation affecting the private practice of medicine, therefore be it

*Resolved,* that the House of Delegates of the Illinois State Medical Society request the Women's Auxiliary to use every avenue of approach possible to bring such information to its members and through them to the public at large.

THE PRESIDENT: As you all know, resolutions not read here can be handed to Dr. Pfeiffenberger. As there is no further business I will entertain a motion for adjournment.

DR. E. S. HAMILTON: I move we adjourn to meet again at 9 o'clock on Thursday morning. (Motion seconded by Dr. J. J. Moore, Chicago, and carried).

The House adjourned at 4:15 P.M.

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*The Second Session of the House of Delegates will appear in the August issue.*

## RESEARCH ON AIRPLANE CRASH INJURIES RESULTS IN NEW SAFETY MEASURES

More ductile instrument panels, control wheels, and the removal of structures which repeatedly cause injury to knees are some of the safety measures initiated as a result of extensive research made on injuries suffered in airplane crashes, according to an editorial in the June 8 issue of *The Journal of the American Medical Association.*

The study was begun in 1942 by the National Research Council at Cornell University Medical College working with the Safety Bureau of the Civil Aeronautics Board and study groups in the Army Air Forces and the Navy.

"Reports which physicians have returned to crash injury research of the National Research Council already have brought about notable improvements," the editorial states. "Instrument panels, for example, which were reinforced so solidly that they demolished the head under heavy impact blows are now being redesigned. by using ductil instead of solid structure, the energy of heavy 'fatal' blows can be distributed and absorbed without fracturing the skull — frequently with only mild or moderate evidence of 'concussion.'

"Control wheels of cast materials which have been found broken in crashes causing puncture of the chest with intrathoracic lesions now are being replaced by wheels which will support the chest and cause lesser injuries of the chest under extremely severe conditions. Structures which repeatedly caused massive injuries of the knees are being eliminated and elements substituted which moderate the chance of such injuries."

To aid in its project the "National Research Council is asking physicians to help in obtaining data on the nature, location and severity of injuries sustained by victims of 'survivable' aircraft accidents."

It is the Council's belief that "people frequently survive serious crashes without dangerous injuries. . . . Study of the factors that allow survival may aid in lessening dangers in aircraft and automobile accidents."

# Council Meeting Minutes

## MINUTES OF THE COUNCIL MEETING JUNE 9, 1946

By official action on the part of the Council of the Illinois State Medical Society, the secretary was instructed to abstract minutes and publish Council actions in the Journal of the Illinois State Medical Society.

Council Minutes
June 9, 1946
Chicago, Illinois

The first meeting of the 1946-1947 fiscal year was held at the Palmer House, Chicago, on Sunday morning, June 9th with the following present: Chairman Walter Stevenson, R. S. Berghoff, I. H. Neece, L. J. Hughes, E. C. Cook, P. E. Hopkins, Oscar Hawkinson, Harry M. Hedge, Wade C. Harker, Leo P. A. Sweeney, H. Prather Saunders, Ralph P. Peairs, Charles H. Hulick, Harlan English, Charles O. Lane, G. C. Otrich, Everett P. Coleman, Charles H. Phifer, James H. Hutton, Mr. John W. Neal, Mr. James Leary, G. Henry Mundt, Robert H. Hayes, Fred H. Muller, W. I. Lewis, George C. McGinnis and the secretary.

The meeting was called to order by the chairman at 9:30 a.m.

MOTION: (Neece-Hughes) that the minutes of the Council meetings held during the annual meeting be approved as mailed to members. Motion carried.

MOTION: (Hamilton-Hopkins) that the Executive Committee of the Council be enlarged to include two new members, thus making a seven man committee. Motion carried.

Neece spoke as President-elect stating that he had no formal report to make, that he appreciated the honor given him, realized the activities ahead for the members of the profession, and asked for assistance and help during his term of office.

The secretary read his report outlining 1946 annual meeting activities, and requesting Council consideration of various changes for 1947.

1. More guest speakers, one for each section, were requested.

2. Chairman and Vice-Chairman for the Committee on Arrangements.

3. Elimination of the evening Oration and scheduling both for daytime sessions.

4. Mid-morning and mid-afternoon breaks in programs for viewing exhibits.

5. A full three day meeting.

The death of Thomas B. Knox, Councilor of the Sixth District, was reported. Doctor Knox served on the Council from 1933 to 1942 when he resigned. He passed away in Quincy late in May. Flowers were sent by the Chairman of the Council for the Society.

The Council should consider several items of new business listed in the report and discussed: The publication of the Constitution and By-Laws to include the changes made by the House of Delegates.

The appointment of the third member of the Committee on Medical Service and Public Relations, a Constitutional Committee appointed by the Chairman of the Council and approved by that body.

The consideration of the Illinois Interprofessional Council Constitution and By-Laws and the appointment of representatives of this Society to represent us on that body.

Authorization to print 10,000 copies of the plan and fee schedule for care of veterans with service connected disabilities in cooperation with the Veterans Administration.

Publication of the minutes of the Council meeting in abstract form in the Journal.

Sending the releases of the A. M. A. Council on Medical Service and Public Relations to county committees throughout Illinois.

The attendance of the president of this Society at the Conference of Presidents and Other Officers to be held in San Francisco during the annual meeting of the A. M. A.

The report of the secretary was received by ruling of the Chairman.

Berghoff reported as president, congratulating the Council on its membership, stating that he hoped to be able to equal the excellent record of the immediate past-president, asking for the cooperation and assistance of the President-elect, and welcoming the new members of the Council. He assured the new members that as they became better acquainted they would find that problems were given serious thought, opinions were aired, ideas expressed, and a spirit of good fellowship maintained.

He desired to stress the need for a revision of the annual program published for distribution at the meeting — the official program should be synchronized

and made more practical for easy use.

Berghoff stated that he realized the importance of his term as president, the problems the profession will be called upon to face, but he had no fear in regard to activities, and knew that the cooperation and team work which would be given him, would push the society far along the road toward progress and advancement.

Stevenson, as Chairman of the Council, announced the committee appointments as follows:

STANDING COMMITTEE: (Under Constitution and By-Laws)

MEDICAL SERVICE AND PUBLIC RELATIONS: James H. Hutton, Chairman, 30 N. Michigan Ave., Chicago; E. S. Hamilton, Kankakee; E. P. Coleman, Canton. Ex officio: R. S. Berghoff, President, 30 N. Michigan Ave., Chicago; Walter Stevenson, Chairman of the Council, Quincy; Harold M. Camp, Secretary, Monmouth, Illinois.

COMMITTEES WITHIN THE COUNCIL

EXECUTIVE COMMITTEE: Walter Stevenson, Chairman, 500 W.C.U. Building, Quincy; Robert S. Berghoff, 30 N. Michigan Avenue, Chicago; Edwin S. Hamilton, Kankakee; Irving H. Neece, 250 N. Water St., Decatur; Percy E. Hopkins, 800 W. 78th Street, Chicago; Oscar Hawkinson, 1011 Lake Street, Oak Park; Harold M. Camp, Monmouth.

FINANCE COMMITTEE: Edwin S. Hamilton, Chairman, Kankakee; Edgar C. Cook, Mendota; Harry M. Hedge, 30 N. Michigan Ave., Chicago.

JOURNAL COMMITTEE: Percy E. Hopkins, Chairman, 800 W. 78th Street, Chicago; Edgar C. Cook, Mendota; Charles H. Hulick, Shelbyville; H. Prather Saunders, 40 East Erie Street, Chicago; Wade C. Harker, 4458 Madison Street, Chicago; H. J. Stewart, Secretary, 715 Lake Street, Oak Park.

COMMITTEES FOR STATE WIDE WORK

EDUCATIONAL COMMITTEE: James H. Hutton, Chairman, 30 N. Michigan Ave., Chicago; Charles P. Blair, Vice-Chairman, Monmouth; Ford K. Hick, res: 1115 N. Grove Ave, Oak Park; Off.: U. of Ill.; George L. Drennan, Jacksonville; C. Paul White, Kankakee; Miss Jean McArthur, Secretary, 30 N. Michigan Ave., Chicago.

SCIENTIFIC SERVICE COMMITTEE: Robert S. Berghoff, Chairman, 30 N. Michigan Avenue, Chicago; Leo P. A. Sweeney, Vice-Chairman, 9715 Winston Ave., Chicago; F. H. Falls, 30 N. Michigan Ave., Chicago; W. I. Lewis, Herrin; J. Roscoe Miller, Northwestern U. School of Medicine, Chicago; Harlan English, Danville; Charles H. Hulick, Shelbyville.

POST GRADUATE EDUCATION COMMITTEE: Robert S. Berghoff, Chairman, 30 N. Michigan Ave., Chicago; George A. Helmuth, Vice-Chairman, 1180 East 63rd St., Chicago; Warren H. Cole, 1853 West Polk Street, Chicago; Frank Deneen, Bloomington; F. Garm Norbury, Jacksonville; Charles O. Lane, West Frankfort; Charles P. Blair, Monmouth.

VETERANS SERVICE COMMITTEE: E. H. Blair, Chairman, 9201 S. Winchester Ave., Chicago; F. T. Brenner, Jr., Quincy; P. R. Blodgett, 1602 Otto Avenue, Chicago Heights; Philip Lewin, 55 E. Washington St., Chicago; Gilbert Edwards, Pinckneyville; George Morgan, Bloomington; M. Herbert Barker, 700 N. Michigan Ave., Chicago.

SCIENTIFIC EXHIBITS COMMITTEE:

GENERAL COMMITTEE: John A. Mart, Chairman and Director of Exhibits, 700 North Michigan Avenue, Chicago; E. E. Nystrom, 410 Main Street, Peoria; Howard L. Alt, 720 North Michigan Avenue.

COMMITTEE ON AWARDS (Personnel not made public or printed).

ADVISORY COMMITTEE TO WOMAN'S AUXILIARY: Frank P. Hammond, Chairman, 222 West North Bank Drive, Chicago; Rollo K. Packard, 826 East 61st Street, Chicago; E. G. Beatty, Pontiac; Harold M. Camp, Monmouth.

COMMITTEE ON PHYSICAL THERAPY: John S. Coulter, Chairman, 122 S. Michigan Ave., Chicago; Milton Schmitt, 3813 Washington Blvd., Chicago; Rudoph Mroz, 303 N. Main St., Rockford; Ralph P. Peairs, Normal; Alfred J. Kobak, 185 N. Wabash Ave., Chicago.

COMMITTEE ON CANCER CONTROL: Warren H. Cole, Chairman, 1853 Polk Street, Chicago; H. E. Davis, 720 N. Michigan Avenue, Chicago; Roswell T. Pettit, Ottawa; John A. Wolfer, 700 N. Michigan Ave., Chicago; J. J. Moore, 55 East Washington St., Chicago; Harry Otten, 107 S. Fifth Street, Springfield; Charles L. Leonard, 206 W. State St., Rockford.

CONSTITUTION & BY-LAWS COMMITTEE: Charles P. Blair, Chairman, Monmouth; G. C. Otrich, Belleville; P. R. Blodgett, 1602 Otto Blvd., Chicago Heights.

ADVISORY COMMITTEE ON VENEREAL DISEASE CONTROL: Irving H. Neece, Chairman, 250 N. Water St., Decatur; B. C. Corbus, 55 E. Washington St., Chicago; Harlan English, Danville; J. E. Wheeler, Belleville.

ETHICAL RELATIONS COMMITTEE: E. S. Hamilton, Chairman, Kankakee; G. Henry Mundt, 30 N. Michigan Avenue, Chicago; Charles H. Phifer, 30 N. Michigan Ave., Chicago.

FIFTY YEAR CLUB COMMITTEE: Andy Hall, Chairman, Mt. Vernon; Channing W. Barrett, 6 N. Michigan Ave., Chicago; E. H. Ochsner, 2256 Lincoln Park West, Chicago; H. O. Munson, Rushville.

MENTAL HYGIENE COMMITTEE: Abraham Levinson, Chairman, 30 N. Michigan Avenue, Chicago; Bert I. Beverly, 8 S. Michigan Ave., Chicago; Gerald M. Cline, Bloomington; Walter M. Whitaker, Quincy; Rudolph G. Novick, 343 So. Dearborn St., Chicago.

INTERPROFESSIONAL RELATIONS COMMITTEE: Walter L. Palmer, Chairman, 950 E. 59th Street, Chicago; G. C. Otrich, Belleville; L. J. Hughes, Elgin; E. C. Cook, Mendota; Warren W. Furey, 6844 Oglesby Avenue, Chicago.

COMMITTEE ON INDUSTRIAL HEALTH: Joseph H. Chivers, Chairman, 836 S. Michigan Ave., Chicago; F. P. Hammond, 222 W. North Bank Drive, Chicago; C. O. Sappington, 330 S. Wells Street, Chi-

cago; H. A. Vonachen, 901 Hamilton Blvd., Peoria; R. I. Barickman, 208 East Main St., Streator.

MATERNAL WELFARE COMMITTEE: F. H. Falls, Chairman, 30 North Michigan Ave., Chicago, Personnel to be named later.

CRIPPLED CHILDREN'S CLINIC COMMITTEE: Richard J. Bennett, Jr., Chairman, 208 S. LaSalle St., Chicago; Ralph P. Peairs, Normal; Charles Papik, 800 W. 78th Street, Chicago; Herbert Richard Kobes, University of Illinois, Extension Service.

COMMITTEE ON TUBERCULOSIS: F. M F. Meixner, Chairman, 101 S. Adams St., Peoria; Frank J. Smejkal, 4328 Elston Avenue, Chicago; Robert K. Campbell, St. John's Sanitarium, Springfield.

ADVISORY COMMITTEE ON REHABILITATION: E. P. Coleman, Chairman, Canton; David B. Freeman, Moline; E. E. Nystrom, 410 Main Street, Peoria; Darwin B. Pond, 4753 Broadway, Chicago.

ADVISORY COMMITTEE ON MEDICAL CARE FOR PUBLIC ASSISTANCE RECIPIENTS: Charles H. Phifer, Chairman, 30 N. Michigan Ave., Chicago; E. S. Hamilton, Kankakee; E. P. Coleman, Canton; Percy E. Hopkins, 800 West 78th St., Chicago; Julius H. Hess, 104 S. Michigan Ave., Chicago. Ex officio: Walter Stevenson, Chairman of the Council, Quincy; R. S. Berghoff, President, 30 N. Michigan Ave., Chicago; Harold M. Camp, Secretary, Monmouth. Sub Committee on Ophthalmology: Harry S. Gradle, 58 E. Washington St., Chicago; Watson Gailey, Bloomington; Walter Stevenson, Quincy. Sub Committee on Radiology: R. T. Pettit, Ottawa; Warren Furey, 7144 S. Jeffrey, Chicago and Fred H. Decker, Peoria.

COMMITTEE TO INVESTIGATE PREPAYMENT PLANS FOR MEDICAL AND SURGICAL CARE: Charles H. Phifer, Chairman, 30 N. Michigan Ave., Chicago; J. H. Chivers, 836 S. Michigan Ave., Chicago; E. P. Coleman, Canton; Frank Deneen, Bloomington; E. S. Hamilton, Kankakee; Charles P. Blair, Monmouth; Robt. W. Keeton, 8 S. Michigan Ave., Chicago; R. J. Bennett, 208 S. LaSalle St., Chicago; P. E. Hopkins, 800 West 78th Street, Chicago. Ex officio: R. S. Berghoff, 30 N. Michigan Ave., Chicago; Walter Stevenson, Quincy; Harold M. Camp, Monmouth; Mr. John W. Neal, Attorney, 30 N. Michigan Ave., Chicago.

MEDICAL ECONOMICS COMMITTEE: Chauncey C. Maher, Chairman, 6 N. Michigan Ave., Chicago; E. S. Hamilton, Kankakee; Emmet B. Bay, 950 E. 59th St., Chicago; V. Thomas Austin, 602 W. University Ave., Urbana; Jay McDonald Milligan, 164 Division St., Elgin; George Halperin, 535 N. Dearborn St., Chicago; Marie Wessels, 720 N. Michigan Ave., Chicago; Thomas C. Browning, 2136 Indiana Avenue, Chicago; Roland R. Cross, Springfield (Director, Department of Public Health); Milton E. Bitter, Quincy; Edwin F. Hirsch, 1439 S. Michigan Ave., Chicago; Ford K. Hick, 25 E. Washington St., Chicago; Wm. J. Bryan, Municipal Tuberculosis Sanatorium, Rockford; John Vonachen, 901 Hamilton Blvd., Peoria; Harry A. Oberhelman, 310 S. Michigan Ave., Chicago.

COMMITTEE ON RURAL MEDICAL SERVICE: Harlan English, Chairman, Danville; G. C. Otrich, Belleville; W. I. Lewis, Herrin; Edgar C. Cook, Mendota; J. C. Redington, Galesburg.

ADVISORY COMMITTEE — SURVEY ON CHILD HEALTH SERVICE — AMERICAN ACADEMY OF PEDIATRICS: John F. Carey, Chairman, Joliet; Gerald Cline, Bloomington; W. L. Crawford, Rockford; George Drennan, Jacksonville; Julius H. Hess, 104 S. Michigan Ave., Chicago; E. T. McEnery, 4458 Madison St., Chicago.

MOTION: (Neece-Otrich) that the Council concur in these appointments. Motion carried.

MOTION: (Hawkinson-Sweeney) that Harold M. Camp serve as Editor, Illinois Medical Journal, for the coming year. Motion carried.

The Chairman was instructed that the nominations be closed and that he cast an unanimous ballot for Camp.

STEVENSON: The next item for Council consideration deals with the 1947 annual meeting — time and place and any proposed changes.

MOTION: (Otrich-Lane) that the 1947 meeting of the Illinois State Medical Society be held at the Palmer House on May 12, 13, 14, 1947, and that it be a full three day meeting, incorporating the suggested changes of R. L. Collison.

Discussion: Otrich: The men downstate will like a meeting opening on Monday.

HARKER: The Chicago men very probably won't like it. On Mondays they plan to pick up their week-end accumulation of work, and the branch societies find Monday a poor meeting night. However this very easily could be made a test year to see how things balance up.

SAUNDERS: I agree with Harker, but I believe this would be counterbalanced by other things. The hotels are definitely to be considered, and we should cooperate with them since the accommodations they can give us can make or break our meeting.

HEDGE: The Chicago crowd would probably be around by Monday afternoon.

SWEENEY: Monday, Tuesday and Wednesday seem more feasible, and this would be a better three full day arrangement than to cut into a full week with the Tuesday, Wednesday, Thursday plan.

BERGHOFF: I agree with Harker. I don't like Monday, Tuesday and Wednesday. Our Constitution and By-Laws definitely call for the other days, however as has been stated, there are many angles to consider — the Hotel especially. What difference in accommodations could be made by moving the meeting up a day? Just how many more rooms would be held for us? We should have some definite figures on this information.

COLEMAN: Men from downstate who want to attend the A. M. A. meeting in June have stated that they do not want to "wreck a week" by attending the state meeting so soon before. This first of the week arrangement should make it possible for them to come in.

HAMILTON: It has been my experience that if the men are coming in at all, or want to attend, most of them will come anyway no matter what the days the meeting is held. Many of the downstate men come in for one or two days, and I doubt if our action will have much bearing on total attendance. We should make a decision because our arrangements with the hotel are important.

CAMP: The motion could be amended and I can take the matter up with Collison.

MOTION: (Hawkinson-Lane) that the motion be amended and the Secretary discuss the matter with Collison and report at the next meeting of the Council. Amendment carried.

Original motion as amended carried.

STEVENSON: The matter of a Chairman and Vice-Chairman of the Committee on Arrangements should be considered by the six Councilors from the C. M. S. together with the President, also a Chicago man. This group should meet with Harker as temporary chairman and bring in three recommendations for these offices at the next meeting of the Council. The meeting can be called by the temporary chairman to suit the convenience of the Chicago men.

COLEMAN reported as a member of the Commission on Medical Care and Hospitals which is making an investigation in Illinois with the possible presentation of a compulsory health bill into the state legislation as its aim. The Commission met for a hearing on May 17th. Camp, Hamilton and Neal were present. The C.I.O. and several other unions had representatives there. The Illinois Hospital Association was represented, and the Illinois Agricultural Association enjoyed strong representation. The United Medical Care was represented by a professor from the University of Chicago, and the Chicago Council of Social Agencies also had representation at the meeting.

LEARY stated that the publicity at the annual meeting was well received, and that the clipping service was sending in material carried by the A.P. and U.P. wires. The clipping service is not entirely adequate and the general opinion expressed was that stories had been well received and good space allocated to activities.

PHIFER reported as chairman of the Committee to study prepayment plans for medical and surgical care outlining in detail the official action on the part of the House of Delegates relative to suggested changes in the policy as written at the present time by the North American Accident Insurance Company. These suggested changes have been taken up with the company as represented by Mr. George Manzelman, the president.

In summary Doctor Phifer stated that of the requested five amendments, the North American Accident Insurance Company has informed us that two of these are necessary requisites of the Insurance Department of the State of Illinois. The Company is willing to grant two of the remaining three requests, leaving only one point that cannot be deleted. This one point is in reference to total disability requirements for sickness under Article III of the policy. The Insurance Company points out that in cases hospitalized you have definite evidence of confinement, or total disability, whereas in patients ill but not hospitalized you have no other satisfactory method to determine loss of time, that if other sound satisfactory methods can be found, they will be given immediate consideration.

In view of the fact that only one point of difference remains as requested by the House on May 16th, and the enactment of the amendments make it necessary that the House of Delegates of the Illinois State Medical Society give further consideration to this policy so the committee can proceed, the Committee is of the opinion that there is an urgent need for immediate additional action on the part of the House. The Committee therefore recommends to the officers and Council of the Illinois State Medical Society that they give consideration to this problem and to what action should be taken in order that the plan may be put into operation in Illinois.

MOTION: (Hopkins-Lane) that the report be adopted. Motion carried.

OTRICH: Are any other companies going to enter this field soon?

PHIFER: We have other companies definitely interested in receiving the endorsement of the Society and interested in writing low cost insurance. So far we have not received or developed any other working arrangement with another company.

HEDGE: It will be necessary to have another meeting of the House of Delegates to get this final problem ironed out as soon as possible. We will have to issue an early call.

HAMILTON: This will have to be done. The House must take definite action on the problem, and until this difference is eliminated the plan itself is stymied. I suggest that our special call be deferred until after the meeting of the A. M. A. as what we hear there may help us in any decision we may have to make.

MOTION: (Hedge-Hulick) that the Council recommend that the President and Chairman of the Council issue a call for a special meeting of the House of Delegates to be held soon after the meeting of the A. M. A. in San Francisco on July 1-5, 1946.

BERGHOFF: Illinois has to have a plan — an official plan which we can endorse. We have already spent thousands of dollars and months of time. The need is there and we must have this meeting. The Chairman of the Council and I will work out the time and place, and will call the meeting.

Motion carried.

HUTTON reported as chairman of the Committee on Medical Service and Public Relations stating that they had received a letter from the C.I.O. They will open a radio station and have offered the state society a place on their program. The committee would like an expression of Council opinion relative to accepting this offer.

MOTION: (Coleman-English) that the committee accept the offer. Motion carried.

Hutton stated that Leary had considered the importance of reaching lay groups and the various sources of contact. The Medical Service and Public Relations Committee has considered the distribution of booklets through school children, clubs and various organizations. A pamphlet would be prepared to present health instructions, numerous society activities, principles in the practice of medicine, etc., so that these pamphlets can carry our story into various fields. The job will be an elaborate one and Council approval is desired before the foundation work is done. The material will be submitted and a cost estimate made before final work is commenced.

MOTION: (Harker-English) that the plan be approved in principle. Motion carried.

Hutton stated that the Editorial Board had considered the presentation of prizes for work done each fiscal year, (1) for the best written article to be passed upon by literary and scientific people, and (2) the outstanding piece of original work as presented in a paper. Both presentations are to be limited to members of the Illinois State Medical Society. For the first class a prize of $100.00, and the second class, a prize of $200.00, this to apply to original scientific articles and scientific editorials. The Committee on Awards shall consist of the Editorial Board, one outstanding newspaper writer and one literary professor from either University of Chicago or Northwestern University.

MOTION: (Hulick-Hamilton) that the Council approve this report and concur in its recommendations. Motion carried.

John W. Neal discussed the activities of the Committee on Medical Service and Public Relations as the executive secretary of the group. He outlined various meetings and spoke relative to the stand taken by the Y. W. C. A. in regard to federal health legislation; outlined activities in Washington, and told of several meetings which he had attended.

STEVENSON: The Executive Committee considered the publication of the Constitution and By-Laws at the meeting last evening, and recommends that 1000 copies be printed for use during the coming year.

MOTION: (Hopkins-Hughes) that this be done. Motion carried.

Camp discussed the two resolutions referred to the Council by the House of Delegates, copies of which were sent to Councilors before the meeting for consideration. It was suggested that these two resolutions, one dealing with prepayment plans for medical and surgical care and the other with Blue Cross activities in Illinois, be turned over to the Committee on Medical Service and Public Relations, and that the Committee make a report to the House at the called meeting this summer.

MOTION: (Hawkinson-Hamilton) so move. Motion carried.

STEVENSON: The Executive Committee recommends that the printing of the plan and fee schedule for the care of veterans with service connected disabilities to be used in Illinois in connection with the Veterans Administration activties, be printed and sent sent out to all members of this society.

MOTION: (Hamilton-Sweeney) so move. Motion carried.

STEVENSON: The Executive Committee recommends that the Constitution and By-Laws of the Illinois Interprofessional Council be turned over to the Constitution and By-Laws Committee of the Illinois State Medical Society and that they report at the next meeting of the Council.

MOTION: (Hulick-Hamilton) so move. Motion carried.

Councilors having suggestions relative to changes in this material were instructed to submit them to Dr. Charles P. Blair, as chairman of the Constitution and By-Laws Committee of the state society.

MOTION: (English-Hedge) that the Council minutes be prepared in abstract and published in the Illinois Medical Journal at the discretion of the Editor, but as soon following the Council meeting as possible. Motion carried.

STEVENSON: The Executive Committee recommends that the Advisory Committee on Child Health Service be made a permanent committee to cooperate with the American Academy in its survey work in Illinois.

MOTION: (Hughes-English) so move. Motion carried.

Camp discussed the request of the Midwest Agricultural Association, created by the government to provide care for migratory workers — immigrants doing work in rural areas. The federal government is charged with the welfare of this group and must provide medical care for them. The fee schedule is standard and the work required by law.

MOTION: (Hulick-Hopkins) that the plan be approved. Motion carried.

Camp discussed the payment of dues by men commissioned and stationed in Veterans Administration Facilities as referred to the Council by our House of Delegates.

SWEENEY: These men have nearly all chosen this work and are there by their own accord; they should pay dues.

MOTION: (Hughes-Otrich) that physicians in Veterans Administration Facilities be required to pay society dues. Motion carried.

STEVENSON: The Executive Committee recommends that the releases received from the A. M. A. Council on Medical Service and Public Relations be mimeographed and sent out to the county committees established to cooperate with our own Committee and the A. M. A. Council.

MOTION: (Hughes-Hawkinson) so move. Motion carried.

The Chairman of the Council ruled that the office of the Secretary be reorganized as outlined to the Council.

STEVENSON: I would like to call on Doctor Coleman to discuss sending our president to California

to attend the Conference of Presidents and other Society Officers to be held during the annual meeting of the A. M. A.

COLEMAN: I was present at the founding of this group and my contacts with them proved to be instructive and valuable. Inside dope on various subjects is presented, and since the Illinois State Medical Society is a member of this organization, I feel we certainly should send our president to attend the meeting.

MOTION: (Coleman-Harker) that the expenses of the President in attending this conference be authorized by the Council on the same basis as the delegates and the secretary. Motion carried.

MOTION: (Hopkins-Hughes) that the bills as audited by the Finance Committee be approved. Motion carried.

The Council adjourned for luncheon at 1:00 p.m.

Respectfully submitted,
HAROLD M. CAMP, M.D., Secretary
By: F. C. Zimmer

## MEDICAL ECONOMICS (Continued)

to Board men and demanding higher standards of practice from the members of the staff, particularly in fields of general surgery or allied specialties such as urology, orthopedics, obstetrics, gynecology, ophthalmology and otolaryngology.

In the lesser population centers, there has been a gradual increase in the number of small clinics, generally with an emphasis on specialization. Presumptively, with an increase in the number of new specialists to be trained, a few will enter practice in the larger cities where competition is keen and a greater number will turn to smaller cities with lesser competition. Undoubtedly, there will be some aggregation into clinic groups as there has been in the past.

The effects of this change is already evident in medical practice today. In small towns where practice is strenuous, in farm communities with country calls, with hospital facilities at a distance, there has been a decrease in the number of doctors. In some communities there are no physicians at all. In some of these towns the in part the responsibilities of the old-time family osteopath and the chiropractor have taken over physician. In serious illness, and particularly since hospital insurance has become available, ambulance service brings the country patient to the hospital, frequently to a specialist's care.

If the trend toward specialism continues on its present curve of growth, it would appear that general practice is to decrease materially in the next decade. The number of individual specialists in cities and towns will increase, and probably the number of small clinics also. Hospital practice appears to be on an upward curve of growth in all fields, surgical, obstetrical, internal medicine and in the other fields.

With better trained physicians and better hospital service, the public should be better served medically than in the past. It is to be hoped that the specialist can assume the many responsibilities of the past between the family and the physician, as capably as the general practitioner. The cost of medical service also must not become prohibitive and must be within reach of all. The advantages and disadvantages will probably become apparent in a relatively short space of time.

C.C.M.

# News of the State

## PERSONALS · COMING EVENTS · MARRIAGES · DEATHS

### ADAMS COUNTY

William V. B. Deering is assuming his duties as head of the pediatric department of the new Physicians and Surgeons Clinic of Quincy. From 1942 to 1946 he served as a major in the army medical corps.

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### BUREAU COUNTY

R. E. Davies has resumed practice in Spring Valley after several years of service in the army medical corps in the European theater.

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### CHAMPAIGN COUNTY

Walter C. Earle, director of the Champaign-Urbana public health district has given up his office after 7 years of service. On June 3rd he assumed his new duties as chief of the out-patient division of the Atlanta, Georgia, Branch of the Veterans' Administration.

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Edgar A. Thacker has left the Carle hospital clinic to begin practice in Canada. He is being replaced by David P. Cordray, formerly of Philadelphia.

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Lucius L. Hutchens, recently discharged from the army medical corps, has returned to Flora to resume practice.

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### COOK COUNTY

Marking the 50th anniversary of their graduation from Northwestern University Medical School, 14 doctors attended their golden reunion at the Morrison Hotel on June 2nd. Of the original class of 73, only 28 are living; 5 of the doctors are from the Chicago area. They are William G. Allen, Rupert M. Parker, Aime Paul Heineck, William C. Van de Benschoten and John F. Van de Roovaart.

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Joseph Reiter, recently released from military service, has been appointed Health Commissioner of the Village of River Grove where he maintains his practice.

Stephen A. Knaisel has been released after 38 months of army duty and has opened his offices on North Clark Street.

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Simon J. Maydet, formerly of Mendota, has been separated from the service and has opened an office on West North Avenue. He is associated with H. Hoyt Cox as assistant in surgery.

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Arch M. Kadow after serving four years with the Ninth Air Force is now back in practice and has announced the opening of a new office on Milwaukee Avenue.

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M. A. Perlstein gave a talk on "Tridione, Its Use in Epilepsy" before the Convention of the American Psychiatric Association in Chicago on May 27th; on the 31st he addressed the Illinois Chapter of International Association for Exceptional Children in Springfield, Illinois, on the subject of "Cerebral Palsy." On June 19th he addressed the National Society for Crippled Children and Adults and on June 26th he spoke before Ruth Lodge on "Handicapped Children."

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Cook County is said to be the first county in Illinois to pass an ordinance regulating the handling, labeling, sale and distribution of milk and milk products. The ordinance provides that only pasteurized milk and milk products are to be sold within the area of jurisdiction of the health department and gives the county health department the responsibility to enforce it. The county health department, of which Dr. Edward A. Piszczek, Chicago, is director, has just made available a report covering health activities for the period 1941-1945. The report presents graphically the service of the department to the suburbs and Cook County. The first organized public health work in this area was begun on July 1, 1940, when the Cook County Public Health Unit was established in the Bureau of Public Welfare as a cooperative agency of the board of commissioners, Illinois Department of Public Health, and U. S.

Public Health Service. On Dec. 10, 1945 the board of commissioners reorganized the unit and established the Cook County Department of Public Health to serve all of Cook County except Chicago, Evanston and Winnetka-Kenilworth. The health department extends its services to more than 600,000 people in an area of 735 square miles.

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The Chicago and Illinois Bar Associations joined with the Chicago Medical Society to correct abuses arising from inexpert medical testimony in civil and criminal courts, the Chicago *Daily News* reported May 20. They have announced adoption of the Minnesota Plan and sent copies of it to all judges and hearing officials. Under the plan, when questionable testimony is offered, the judge, lawyer or physician should write a letter to the medical society giving the name of the medical witness, the name and number of the case and where and when it was tried. A committee of the medical group will, at its own expense, and with the aid of the bar association, obtain a transcript of the record, and, if need be, call in specialists in the field of medicine involved. If the committee finds that the medical witness testified falsely or lacked knowledge of the subject and his testimony disregarded the truth, proper disciplinary action will be taken before the Illinois Department of Registration and Education. Likewise judges and other parties taking part in such cases will write a similar letter to the appropriate bar group, if there is reason to believe that the attorney using such testimony did so knowing its falsity or lack of qualification of the witness.

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Dr. John R. Mote, formerly associate director of research at the House of the Good Samaritan, Boston, and assistant in the department of preventive medicine, Harvard Medical School, Boston, has been appointed medical director of the pharmaceutical division of the Armour Laboratories. Dr. Mote graduated at Harvard Medical School in 1935 and went to London in 1940 as liaison officer to assist in setting up the Harvard-American Red Cross Hospital. While in London he was medical adviser to the American Red Cross and American liaison officer in the Ministry of Health. When he returned to the United States in 1941 he enlisted in the United States Naval Reserve and at the request of the British Supply Council became medical director of the British Supply Mission.

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Dr. Louis B. Shapiro, recently released from military service, has been appointed clinical director of the Chicago State Hospital.

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Lieut. Col. Vincent P. Graham, who has been chief of x-ray services at Camp Grant, Vaughan General Hospital and the Regional Hospital at Fort Ord since 1942, has been appointed assistant professor of roentgenology at the University of Chicago School of Medicine. — Dr. Lester S. King, recently released from the army, has been appointed pathologist and director of laboratories on a full time basis at the Illinois Masonic Hospital, serving also as director of the educational program.

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New officers of the Illinois Psychiatric Society are Joseph A. Luhan, Chicago, president, Delmar Goode, Downey, Vice-president, Charlotte G. Babcock, Chicago, Secretary-treasurer.

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A statue of Apollo, commemorating the founding of the First Chapter of Alpha Omega Alpha, national honorary medical fraternity, on the Chicago campus of the University of Illinois in 1902, was unveiled in ceremonies at the University of Illinois College of Medicine on June 5th. Speakers included Walter Bierring, J. J. Moore, Raymond B. Allen, D. J. Davis. Warren H. Cole was master of ceremonies.

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Malcolm T. MacEachern was installed as president of the Chicago Medical Society at the annual meeting and dinner on June 19th. Warren W. Furey was named president-elect and Willard O. Thompson, secretary.

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Dr. John H. Stokes, professor emeritus of dermatology and syphilology, University of Pennsylvania School of Medicine, Philadelphia, and director, Institute for the Study of Venereal Disease, University of Pennsylvania, will deliver the first William Allen Pusey Memorial Lecture of the Institute of Medicine of Chicago at a meeting with the Chicago Society of Internal Medicine and the Chicago Dermatological Society, October 25, at the Palmer House. His subject will be "The Skin as a Field of Research." Dr. Pusey, who once served as President of the American Medical Association, died Aug. 29, 1940.

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On April 15 the American Committee on Maternal Welfare, Inc., moved to a new office at 24 West Ohio Street, Chicago 10. All correspondence concerning the affairs of the committee, the American Congress on Obstetrics and Gynecology, *the Mother* or the National Federation of Obstetric-Gynecologic Societies should be sent to this new street address and postal zone.

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The Army Commendation Ribbon was recently awarded to Col. Harold C. Lueth, Chicago. According to the citation accompanying the award, "During World War II the Medical Department carried out its mission with outstanding success. This achievement was made possible only through

the combined efforts of all Medical Department personnel. Your service with the Medical Department has been exceptional when compared with others of the same grade of similar position, and I wish to commend you for your outstanding contribution as liaison officer between the Office of the Surgeon General and the American Medical Association from March 15, 1942 to Feb. 25, 1945." Dr. Lueth graduted from Northwestern University Medical School, Chicago, in 1930 and entered the service Oct. 1, 1940. He was recently appointed dean of the University of Nebraska College of Medicine, Omaha.

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At the annual meeting of the Chicago Society of Internal Medicine, the following officers were elected: Laurence E. Hines, president, Henry T. Ricketts, vice-president and Richard B. Capps, secretary-treasurer.

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The Legion of Merit was recently awarded to Col. Midian O. Bousfield, first Negro member in the Army Medical Corps and now the first Negro medical officer commissioned in the reserve as a full ranking colonel. The citation accompanying the award read, in part, that "Colonel Bousfield played an important part in the excellent racial relationship" at Fort Hauchuca, Arizona, "where a mixed racial population required a tolerant and understanding leader." Dr. Bousfield graduated from Northwestern University Medical School, Chicago, in 1909 and entered the service June 7, 1942.

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A competitive examination for the purpose of filling the positions of health officer of the Champaign-Urbana health district, Champaign, and the Stickney District Health Department, Stickney, will be held in Chicago on July 20. Admission to the examination will be limited to persons possessing minimum qualifications of education and experience. Further information may be obtained by writing to Dr. Roland R. Cross, Director, Illinois Department of Public Health, Springfield.

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## DEKALB COUNTY

Percy Hopkins and Charles H. Phifer of Chicago presented a program on "Prepayment Medical Insurance" before the DeKalb County Medical Society on June 18th.

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George G. Green of Salem, is new assistant at the Sycamore Clinic. He has recently received his discharge from the armed forces after serving 37 months, 20 of which were spent overseas.

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## DOUGLAS COUNTY

Walter C. Blaine of Tuscola was made a member of the "Fifty Year Club" of the Illinois State Medical Society at the Annual Meeting at the Palmer House.

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## FAYETTE COUNTY

A special meeting of the Fayette County Medical Society was held June 11th in honor of Edmond P. Staff who was presented with his button and certificate as a member of the "Fifty Year Club." After his graduation from the Missouri Medical College he started practicing in Ramsey. He served in the medical corp during World War I; has been mayor of Ramsey, a member of the high school board for 30 years and at the present time is president of the community high school board.

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## FORD COUNTY

Earl C. Bucher who entered the navy in 1944 has returned to Gibson City to practice after seeing service at Pearl Harbor and Guam.

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## FRANKLIN COUNTY

J. J. Sievers of the State Department of Public Health addressed the Franklin County Medical Society at Benton on June 27th, subject "Infantile Diarrhea."

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Walter Pope Alvis recently discharged from the army air corps where he spent two and one-half years in the practice of flight surgery and another year in an army hospital, has returned to civilian practice in Benton. He will share offices with his father, Walter H. Alvis, who has been in practice more than 40 years.

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## HANCOCK COUNTY

The Hancock County Medical Society met June 4th at Carthage. Charles P. Blair of Monmouth was the speaker.

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## HENRY COUNTY

Peter J. Timmons has returned to Woodhull where he will resume the practice of medicine after nearly four years' service in the armed forces.

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Marvin E. Eckberg recently discharged from the army medical corps has returned to Galva to resume the practice of medicine. He entered the service in 1943 and was stationed at an isolation hospital, the West Tennessee Medical center at Memphis, Tenn.

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Fred J. Stewart, Kewanee, was recently elected president of the Henry County Medical Society. Nolan Montgomery was elected vice-president and C. P. White, secretary-treasurer. P. J. McDermott who has been secretary-treasurer for more than 20 years asked to be relieved of his responsibilities. He was presented with a pen and pencil set by members of the society.

JACKSON COUNTY

William Dean Mohlenbrock, Murphysboro, who was in the army medical corps, has been assigned to the Anna State Hospital by Governor Dwight H. Green.

JEFFERSON-HAMILTON COUNTIES

Andy Hall, former State Director of Public Health and veteran of three wars, was honored as the outstanding citizen of the year by the Mt. Vernon Chamber of Commerce. The presentation said, in part, "No citizen is more beloved or respected than Dr. Andy Hall. His every effort and all of his energies are devoted to the development of Mt. Vernon. — At a time when the young doctors of the city were in military service he carried on day and night — He was one of the few always available on night calls."

KANE COUNTY

Anthony Barone, Chicago, addressed the Delnor Staff of St. Charles on June 11th, subject, "Treatment of Varicosities and Venous Thrombosis."

LAKE COUNTY

Dr. Douglas Boyd has been appointed president of the Highland Park Board of Health, succeeding Dr. Donald E. Rossiter, Highland Park, who resigned, effective April 1. Dr. Rossiter had held the position since 1931, except while on military leave.

LIVINGSTON COUNTY

Robert P. Lykkebak whose home was at Heyworth has located in Chatsworth where he is associated with H. L. Lockner and C. E. Branch, of Piper City. During the war, he served with the Fifth General Hospital Unit in the First Infantry in England, France, Belgium and Germany.

McLEAN COUNTY

John W. Turner of Wichita, Kansas, has been appointed director of the McLean County Health Department, Dr. Ralph P. Peairs, president of the board of directors, has announced.

MACON COUNTY

Gabriel B. Kramer, formerly with the Youngstown Hospital, Ohio, has begun his duties as pathologist at St. Mary's Hospital, Decatur.

MADISON COUNTY

Armin W. Doctor, recently discharged from the army medical corps, has opened offices in Edwardsville and Marine for the practice of medicine.

Edward C. Ferguson, Edwardsville, was showered with gifts when he observed his 50th anniversary in the practice of medicine in May.

Robert B. Lynn recently of the army medical corps, has opened an office in Alton for the practice of general surgery.

MARION COUNTY

F. C. Katzenstein after 3 years in the service, has returned to reestablish practice in Salem.

MONTGOMERY COUNTY

Homer A. Seymour, Hillsboro, was presented in May with a "Fifty Year Pin" for having practiced his profession in Illinois for half a century.

MORGAN COUNTY

T. O. Hardesty, Jacksonville, and James A. Cravens of Springfield, were honored by the Morgan County Medical Society for having completed 50 years' medical practice in June. A banquet was served at the Dunlap Hotel and Stanley Gibson, Chicago, presented the scientific program. Walter Stevenson, Quincy, was master of ceremonies.

OGLE COUNTY

Nathan Isbicky, formerly associated with L. Warmolts, Oregon, after 39 months in the service, was cited for "service beyond the line of duty" and recently received his discharge.

PEORIA COUNTY

Four physicians who have been serving in the armed forces have returned to Peoria to resume practice. They are Glen I. Allen, R. C. Dunseth, Ray W. King, and H. Sargent Howard.

H. G. Eichhorn, Peoria, attended the 50th anniversary of the graduation of his class from Northwestern University Medical School in Chicago in June. He and the others of the class were presented with Golden Reunion certificates by the Northwestern University Alumni Association.

Karl A. Meyer, Chicago, addressed the Peoria Medical Society on June 4th, subject, "Primary Resections for Carcinoma of the Colon."

RANDOLPH COUNTY

The Five County Medical Society Organization held a scientific meeting on June 27th at the Royal Hotel, Chester. W. W. Fullerton, Steeleville, Secretary of Randolph County Medical Society was in charge of the arrangements. Dr. L. W. Dean, Jr., of St. Louis, spoke on "Recent Advances in the Treatment of Diseases of the Ear, Nose & Throat."

ROCK ISLAND COUNTY

Eugene Moses, after three years in the army

medical corps, has returned to Rock Island to civilian practice.

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Edwin F. Condon who has practiced for many years in Rock Island, is to be the resident physician and surgeon in the Milan General Hospital now under construction.

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Joseph K. Hanson of Moline was elected president of the Iowa-Illinois Central District Medical Association at the annual dinner meeting in May.

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### ST. CLAIR COUNTY

Robert A. Little after an absence of 4 years during which time he was with the U. S. Public Health service, has returned to East St. Louis to practice.

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### SALINE COUNTY

The Saline County Medical Society held a meeting in Harrisburg on May 23rd. Plans for future meetings with prominent guest speakers were outlined.

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### TAZEWELL COUNTY

Lloyd Finley Teter who has been serving in the U. S. Navy Medical Corps has returned to Pekin to the practice of medicine and surgery.

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### VERMILION COUNTY

L. Schleissner has moved to Hume to practice and was given a temporary office by the American Legion until he can find a permanent location.

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John Urbas, who has been overseas serving in the armed forces and recently discharged, has taken the office formerly occupied by James McKibben and will practice in Georgetown.

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### WABASH COUNTY

Ben F. Stein who returned recently from serving almost 4 years in the army, 18 months of which were spent in England, has returned to Mt. Carmel to civilian practice.

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### KANKAKEE COUNTY

Orville L. Denys who has been serving in the armed forces has decided to return to Momence to medical practice after a six weeks refresher course at Cook County Hospital.

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### WAYNE COUNTY

G. H. Hill has resumed medical practice in Fairfield.

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### WHITE COUNTY

George L. Cremeens, Springerton, was awarded a "Fifty Year Pin" after having practiced medicine over 50 years in White County.

### WHITESIDE COUNTY

Clarence L. Mueller, recently discharged from the army medical corps is now associated with C. G. Beard, Sterling.

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### WILL COUNTY

Cecil A. Z. Sharp, Will County public health director, has been elected president for 1947 of the Illinois Public Health Association.

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### WINNEBAGO COUNTY

Wilbur A. Armstrong, who saw active duty in both Europe and the Pacific during 3 years of army service, has opened an office in Loves Park for the practice of medicine and surgery.

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## MARRIAGES

Roy L. Walgren of Pearl City, to Miss Gladys M. Manson, of Rockford, May 18th.

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## DEATHS

James R. Barnes, Cicero; Jenner Medical College, 1904. Took post graduate work at Harvard University and Rush Medical College and specialized in internal medicine. Died, aged 69, June 15th after an illness of 6 weeks.

James T. Blakely, Fairfield; Barnes Medical College, St. Louis, Mo. Served in the Spanish-American War. Delegate to the Illinois State Medical Society meetings for the past 20 years; secretary of Wayne County Medical Society for many years. After a recent check-up in St. Louis, he was convinced he had cancer of the stomach. Sunday, June 9th he was found on the ground under his window dead. He was 72 years of age.

Samuel W. Coffman, Maywood; College of Medicine and Surgery, Chicago, 1896. Died May 26th, at Vaughan General Hospital after an illness of 3 and one-half years. He was 70 years old.

Henry J. Dern, Chicago; Rush Medical College, 1898. Had practiced on Chicago's south side for 46 years. Died May 23rd, aged 71.

William Percy Duncan, Jacksonville; Northwestern University Medical School, 1903. Had practiced in Jacksonville for 43 years. Died, aged 67 in June, '46.

Frederick John Eberspacher, Pana; Bellevue Hospital Medical College, New York, 1897. Was one of the founders of the Huber Memorial Hospital and past president of the Christian County Medical Society. Died June 5th at the age of 79.

Thomas M. Hardie, Chicago; University of Toronto, 1888. Former editor-in-chief of the Annals of Otology and Laryngology. Died June 2nd, aged 84, in his home.

Sherman R. Hurlbut, Evanston, retired; Rush Medical College, 1899. Had practiced in Chicago for 30 years. Died June 8th at the age of 70.

Anna Medaris, Chicago Heights, retired; Jenner Medical College, 1900. Former township supervisor. Died May 16th, aged 84.

Joseph F. Mieczynski, North Chicago; Chicago College of Medicine and Surgery, 1911. Was medical officer overseas in World War I. For 11 years he was superintendent of communicable diseases in the Illinois Public Health Department. Died May 15th, aged 58.

Paris M. Nation, Anna; St. Louis College of Physicians and Surgeons, 1904. Had served McLeansboro as a physician for many years until his appointment in 1935 to the staff at Anna State Hospital. Died May 15th from a cerebral hemorrhage at the age of 68.

William Spencer Needham, Pekin; University of Louisville School of Medicine, Ky., 1912. Was practicing physician for 25 years. Died of a heart attack June 7th, at the age of 56.

Adam Leo Szwajkart, Chicago; University of Illinois College of Medicine, 1911. World War I army captain; former staff member of the Municipal Tuberculosis Sanitarium. Died May 24th following a long illness at the age of 51.

Harry M. Thometz, Oak Park; Rush Medical College, 1911. Had practiced in Chicago for 35 years. Died following a heart attack June 16th at the age of 57.

Frank Peter Jacob Was, Chicago; Rush Medical College, 1905. Associate staff of Roseland Community Hospital. Died April 18th, aged 67, of coronary thrombosis.

Melchior Whise, Chicago; Rush Medical College, 1893. Former president of the Northwest Side Branch of the Chicago Medical Society. Member of Staff of Lutheran Deaconess Hospital for many years. Had practiced in Chicago over 50 years. Died June 3rd, aged 77.

A new radio series dedicated to the medical profession was inaugurated by Columbia Broadcasting System on June 4th. This program sponsored by Schenley Laboratories, Inc., is known as "Encore Theater" and will be heard every Tuesday evening.

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Tuberculosis is a communicable disease, and, now that the disease has been almost completely eradicated from cattle, it is safe to say that each new human case comes from some other human case. However, because the infection may remain latent in the human body for years and even decades, this task presents difficulties which are not found in the control of more acute communicable diseases. Also, because factors such as nutrition, crowding, and the standard of living play an important role, the control of the disease is a problem which can be solved satisfactorily only by community action. It is not a task which can be delegated to the Health Department alone. In addition we must secure the cooperation of the medical profession and of the hospitals, of public-spirited citizens, of industry and of the general public. Ann'l Rep't, Cattaraugus Co. (N.Y.) Health Dept., 1944.

The tuberculin test indicates the presence or absence of living tubercle bacilli. It "screens out" uninfected persons in survey work and assists in the examination for "contacts" of tuberculous persons. It is important in the collection of epidemiologic data and indicates when an exposed child becomes infected, thus pointing to the source of infection. Sydney Jacobs, M.D. The Journal Lancet, March, 1946.

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Protection from tuberculosis is bound up intimately with the social conditions which lie at the basis of national health, of which tuberculosis is indeed the most sensitive index. Immunity to tuberculosis is never absolute. It can always be breached by the frontal attacks of repeated infection or by the more insidious infiltrations of poverty, malnutrition, bad housing and the many conditions which go with them. Conversely, whatever part inheritance plays in some families, there is surely no such thing as inevitability in this disease. Anything which raises the health of a nation raises its basic immunity to tuberculosis and it is that basic immunity which faces the first onslaught of the infection. Subsequent immunity is at best finely balanced and its fate may well rest on the social status of the individual and the hardships which life holds for him. Charles Cameron, M.D., NAPT Bull., Feb., 1946.

# ANALYSES OF NUTRITIVE VALUES:



## Campbell's STRAINED BABY SOUP

| | CHICKEN | LIVER | LAMB | BEEF | VEGETABLE |
|---|---|---|---|---|---|
| Solids % | 11.8 | 13.3 | 13.9 | 13.7 | 13.4 |
| Protein % | 2.63 | 3.42 | 3.09 | 3.91 | 1.95 |
| Fat % | 1.5 | 0.9 | 2.1 | 0.9 | 0.5 |
| Carbohydrate % by difference | 6.4 | 7.5 | 7.2 | 7.6 | 9.3 |
| Calories per ounce | 14 | 15 | 17 | 15 | 14 |
| Crude Fibre % | 0.15 | 0.29 | 0.30 | 0.22 | 0.43 |
| Calcium % | 0.026 | 0.013 | 0.046 | 0.046 | 0.024 |
| Phosphorus % | 0.042 | 0.065 | 0.068 | 0.068 | 0.051 |
| Iron Mg. per 100 g. | .22 | .72 | .35 | .40 | .73 |
| Copper Mg. per 100 g. | .24 | .35 | .12 | .17 | .24 |
| Manganese Mg. per 100 g. | .075 | .173 | .054 | .053 | .018 |
| Vitamin A—I. U. Per 100 g. | 1766 | 7000 | 1130 | 1693 | 2550 |
| Thiamine Mg. per 100 g. | .018 | .080 | .036 | .037 | .069 |
| Riboflavin Mg. per 100 g. | .040 | .62 | .068 | .072 | .064 |
| Ascorbic Acid Mg. per 100 g. | 1.1 | 7.3 | 2.7 | 3.9 | 7.5 |
| Niacin Mg. per 100 g. | .77 | 1.54 | 1.22 | 1.29 | 1.05 |

*5 KINDS:*

*LIVER*
*CHICKEN*
*LAMB*
*BEEF*
*VEGETABLE*

*All in Glass Jars*




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new, nontoxic, smaller dosage sulfonamide

# 'SULFATHALIDINE'

*Phthalylsulfathiazole*

**for treatment of colon infections**

RESULTS OBTAINED WITH 'SULFATHALIDINE' PHTHALYLSULFATHIAZOLE*

| DISEASE | GOOD 84% | FAIR 6% | POOR 10% |
|---|---|---|---|
| Chronic Ulcerative Colitis | 20 acute<br>54 chronic | 1 acute<br>1 chronic | 1 acute<br>3 chronic |
| Bacillary Dysentery | | 2 chronic | |
| Giardia Lamblia | 2 acute<br>6 chronic | | |
| Paratyphoid | | 2 chronic | |
| Dientameba Fragilis | 2 acute | | |
| Amebic Colitis | | | 4 acute<br>2 chronic |
| Total Number of Patients: 100 | 24 acute<br>60 chronic | 1 acute<br>5 chronic | 5 acute<br>5 chronic |

Smaller dosage, nontoxicity, effective bacteriostasis are outstanding therapeutic features of 'Sulfathalidine' *phthalylsulfathiazole*, the new enteric sulfonamide developed by the Medical Research Division of Sharp & Dohme.

The new compound is indicated in the treatment of ulcerative colitis, regional ileitis, as a supplement to therapy of amebiasis, giardiasis, and paratyphoid infections, and as an adjunct to intestinal surgery.

'Sulfathalidine' *phthalylsulfathiazole* maintains a high bacteriostatic concentration in the gastrointestinal tract, profoundly reducing Escherichia coli, clostridia and related organisms. Only 5% of the ingested drug is absorbed and this is rapidly excreted by the kidneys.

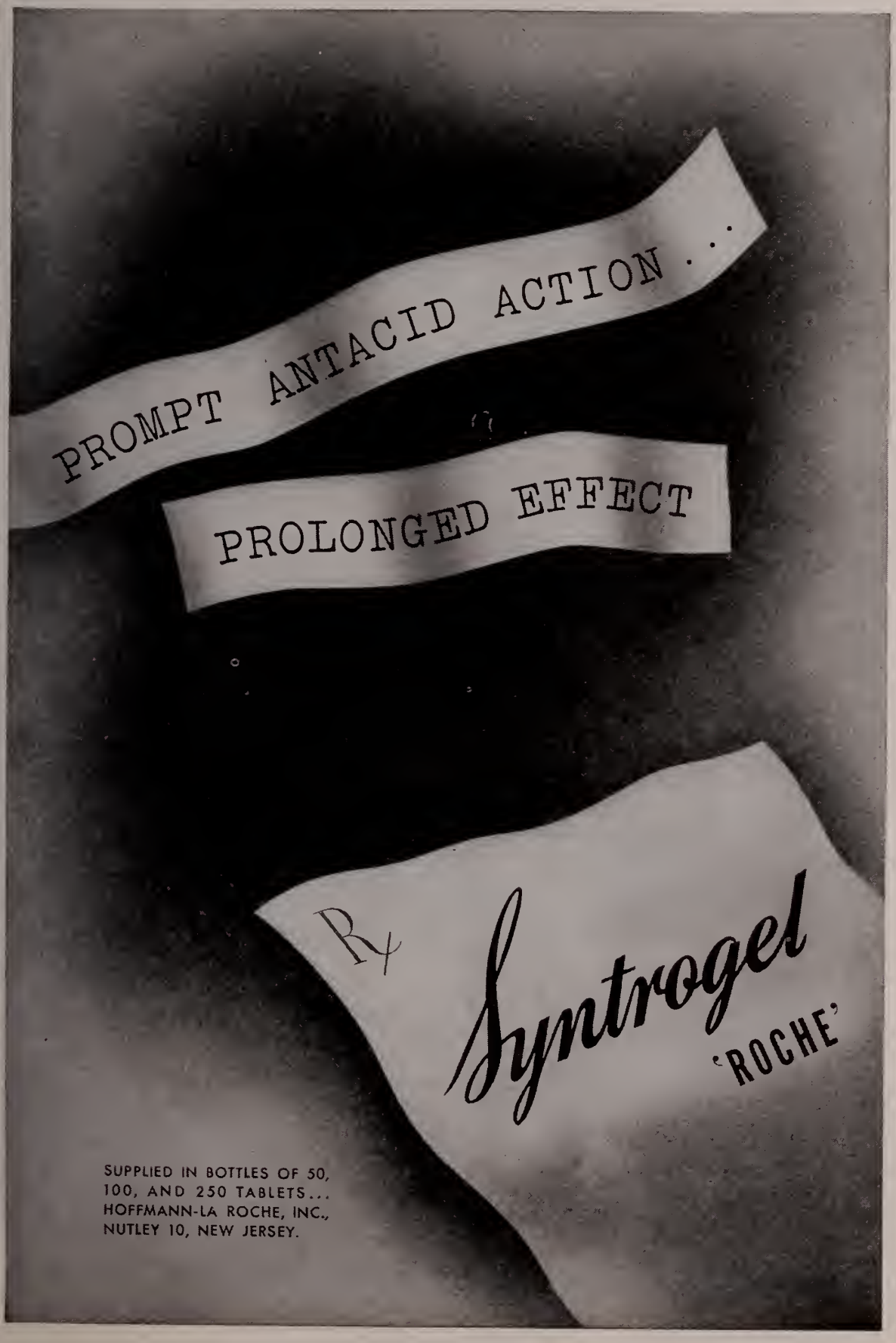
Administered recently to 100 patients with colon infections, 'Sulfathalidine' *phthalylsulfathiazole* was effective in the treatment of 90.* The clinician reported:

"*It is my impression that phthalylsulfathiazole is less toxic and more bacteriostatic than any intestinal agent used previously and that, because it has these properties, smaller doses of the drug may be used to advantage.*"*

'Sulfathalidine' *phthalylsulfathiazole* is supplied in 0.5-Gm. compressed tablets in bottles of 100, 500, and 1,000. Sharp & Dohme, Philadelphia 1, Pa.

*J.A.M.A., *129*:1080, Dec. 15, 1945.

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PROLONGED EFFECT
℞
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# ITS PROTEINS ARE OF

## *High Biologic Value*

The role of protein metabolism in the post-surgical patient is well established. Rapid restoration of nitrogen balance minimizes the danger of surgical shock, speeds tissue repair and healing, and facilitates hemoglobin regeneration. Post-operatively, this relationship is reflected in the greatly increased protein requirement, which may be as great as 2 Gm. per Kg. of body weight. The delicious food drink made by mixing Ovaltine with milk provides a convenient and advantageous means of satisfying this augmented nitrogen need, since it supplies an abundance of protein of high biologic value. Three glassfuls daily provide 32.1 Gm. of complete protein containing all essential amino acids.

In addition, this food supplement contains many other nutrients needed during the postoperative period — readily utilized carbohydrate, easily emulsified fat, B complex and other vitamins including ascorbic acid, and essential minerals. Its delicious taste makes it acceptable to all patients, and because of its low curd tension and easy digestibility, it is tolerated almost as soon as liquids can be taken.

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*Ovaltine*

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½ oz. of Ovaltine and 8 oz. of whole milk,* provide:

| | | | |
|---|---|---|---|
| CALORIES | 669 | VITAMIN A | 3000 I.U. |
| PROTEIN | 32.1 Gm. | VITAMIN $B_1$ | 1.16 mg. |
| FAT | 31.5 Gm. | RIBOFLAVIN | 1.50 mg. |
| CARBOHYDRATE | 64.8 Gm. | NIACIN | 6.81 mg. |
| CALCIUM | 1.12 Gm. | VITAMIN C | 39.6 mg. |
| PHOSPHORUS | 0.939 Gm. | VITAMIN D | 417 I.U. |
| IRON | 12.0 mg. | COPPER | 0.50 mg. |

*Based on average reported values for milk.




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- Soft, *greaseless* cream combining semi-colloidal calamine and zinc oxide with benzocaine.

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WHENEVER

*Impaired Fat Digestion*

MUST BE OVERCOME

Impairment of fat digestion implies more than loss of available caloric food energy to the organism. It involves the failure of absorption of the fat-soluble vitamins A, D, E, and K, together with the development of deficiency manifestations. Particularly severe is vitamin K deficiency with prolongation of the prothrombin clotting time and the consequent hemorrhagic diathesis.

Whenever impaired fat digestion must be corrected, Degalol is specifically indicated. Degalol—chemically pure deoxycholic acid, a normal constituent of human bile — represents the biliary component chiefly concerned with fat digestion and absorption. Its administration in small dosage virtually normalizes fat digestion within the small bowel when lipase is not deficient, and with it absorption of the fat-soluble vitamins D, E, and K, and carotene. It is especially valuable in correcting the hemorrhagic complications of obstructive jaundice, where choleresis is undesirable. Degalol proves useful whenever impaired fat digestion is suspected, and particularly in the treatment of postprandial epigastric distress and fat intolerance not associated with chronic gallbladder disease. Supplied in tablets of 1½ gr., boxes of 100 and 500.

**Degalol**

REG. U. S. PAT. OFF.

CHEMICALLY PURE DEOXYCHOLIC ACID

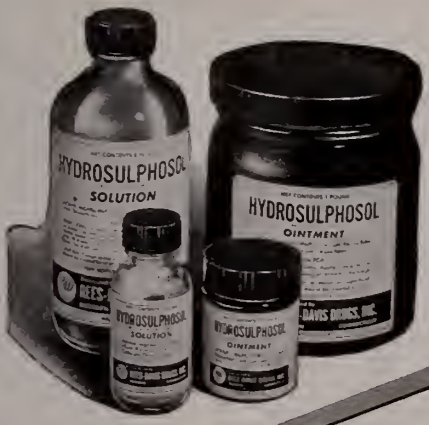
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DIVISION OF AMES COMPANY, INC.

NEW YORK 13, N. Y.

# *A Fundamental Approach*
## TO SULFUR METABOLISM

# HYDROSULPHOSOL



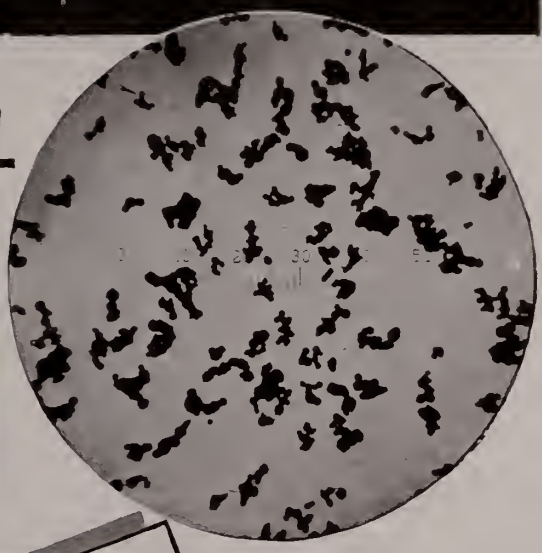



*Illustration showing flowers of sulfur magnified 82X: small divisions = 10 microns. The size of the colloidal sulfur particle in Hydrosulphosol is estimated at 1/1000 of a micron or 1/10,000 of the small division particle illustrated.*

A true solution of sulfur bearing compounds resulting solely from the reduction of flowers of sulfur by a catalytic process. In aqueous solution, it is capable of releasing its unusually high concentration of sulfhydryl ion in readily utilizable form . . . without evidence of toxic reaction.

Its therapeutic importance may best be evaluated by the fact that the —SH radical of the cysteine forms the active group in glutathione, alone of reported importance in connection with tissue oxidations.

Hydrosulphosol is indicated in the management of burns, ulcers and pathological conditions in which sulfur metabolism is a clinical consideration.

*Reprints of scientific papers by authoritative investigators available on request.*

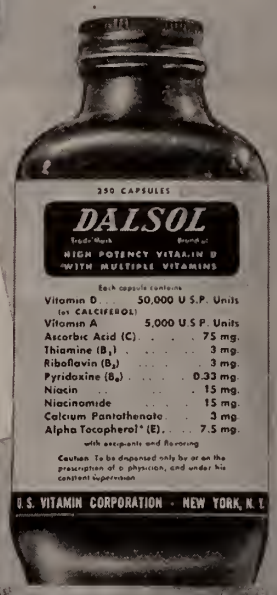
Rees-Davis Drugs, Inc.
MERIDEN, CONNECTICUT

# DALSOL

(U. S. VITAMIN)

Each DALSOL Capsule contains:

| | |
|---|---|
| Vitamin D (as CALCIFEROL) | 50,000 U.S.P. Units |
| Vitamin A | 5,000 U.S.P. Units |
| Ascorbic Acid (C) | 75 mg. |
| Thiamine ($B_1$) | 3 mg. |
| Riboflavin ($B_2$) | 3 mg. |
| Pyridoxine ($B_6$) | 0.33 mg. |
| Niacin | 15 mg. |
| Niacinamide | 15 mg. |
| Calcium Pantothenate | 3 mg. |
| Alpha Tocopherol (E) | 7.5 mg. |




Combining intensive dosage of Vitamin D (Calciferol) with high potency multivitamin therapy, DALSOL presents an important adjunct to the optimal nutrition so essential to the arthritic's welfare. DALSOL can help to

1. meet higher-than-normal vitamin needs,
2. provide the therapeutic effects which may reside in the vitamins,
3. reduce deficiency vulnerability of affected joints,
4. counter gastro-intestinal dysfunction, fatigue, weight loss, nervousness, anemia, if and to the extent that such symptoms are due to avitaminoses.

## Multi-Nutritional Support as Adjunct Therapy in ARTHRITIS

Bottles of 100, 250, 500 and 1000 capsules

*Professional samples and literature*

**U. S. VITAMIN CORPORATION** • **250 East 43rd St.** • **New York 17, N. Y.**



# "I'm going to grow a hundred years old!"

*. . . and possibly she may— for the amazing strides of medical science have added years to life expectancy*

● It's a fact—a warm, wonderful fact—that this five-year-old child, or your own child, has a life expectancy almost a whole decade longer than was her mother's, and a good 18 to 20 years longer than that of her grandmother. Not only the expectation of a longer life, but of a life by far healthier. Thank medical science for that. Thank your doctor and thousands like him . . . toiling ceaselessly . . . that you may enjoy a better life.




According to a recent independent nationwide survey:

## More Doctors Smoke Camels

*than any other cigarette*

R. J. Reynolds Tobacco Company, Winston-Salem, N. C.




*Schematic section of villi showing fluid exchange system through blood vessels whereby water is drawn into the bowel to help form "liquid bulk."*

## SAL HEPATICA'S Liquid Bulk creates *Gentle* but Effective *Pressure*

For gentle yet speedy relief for constipated patients, more and more physicians turn to SAL HEPATICA.

An effervescent, saline laxative, SAL HEPATICA has achieved an enviable position because it follows nature's own methods, utilizes the gentle pressure of "liquid bulk" to stimulate peristalsis.

When SAL HEPATICA is administered, a large amount of water is retained in the intestinal tract. This exerts a gentle pressure which leads to a speedy expulsion of the colonic contents . . . usually within an hour.

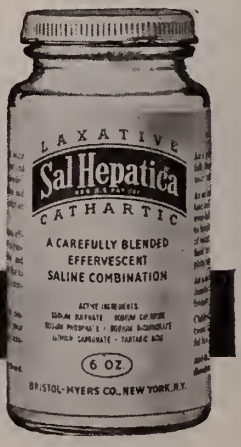
For quick relief for constipated patients, remember SAL HEPATICA.

# SAL HEPATICA




*A Product of* BRISTOL-MYERS COMPANY
19RR West 50th Street • New York 20, N. Y.

GENTLE PRESSURE FOR GENTLE YET THOROUGH LAXATION






***A new treatment for***

## Poison Ivy, Poison Oak, and Poison Sumac Dermatitis

# THYPTOL

REG. U. S. PAT. OFF.

**KAOLIN IN ALUMINA GEL**
**WITH PHENOL**

THYPTOL CHECKS symptoms *at once* . . . The skin heals quickly.

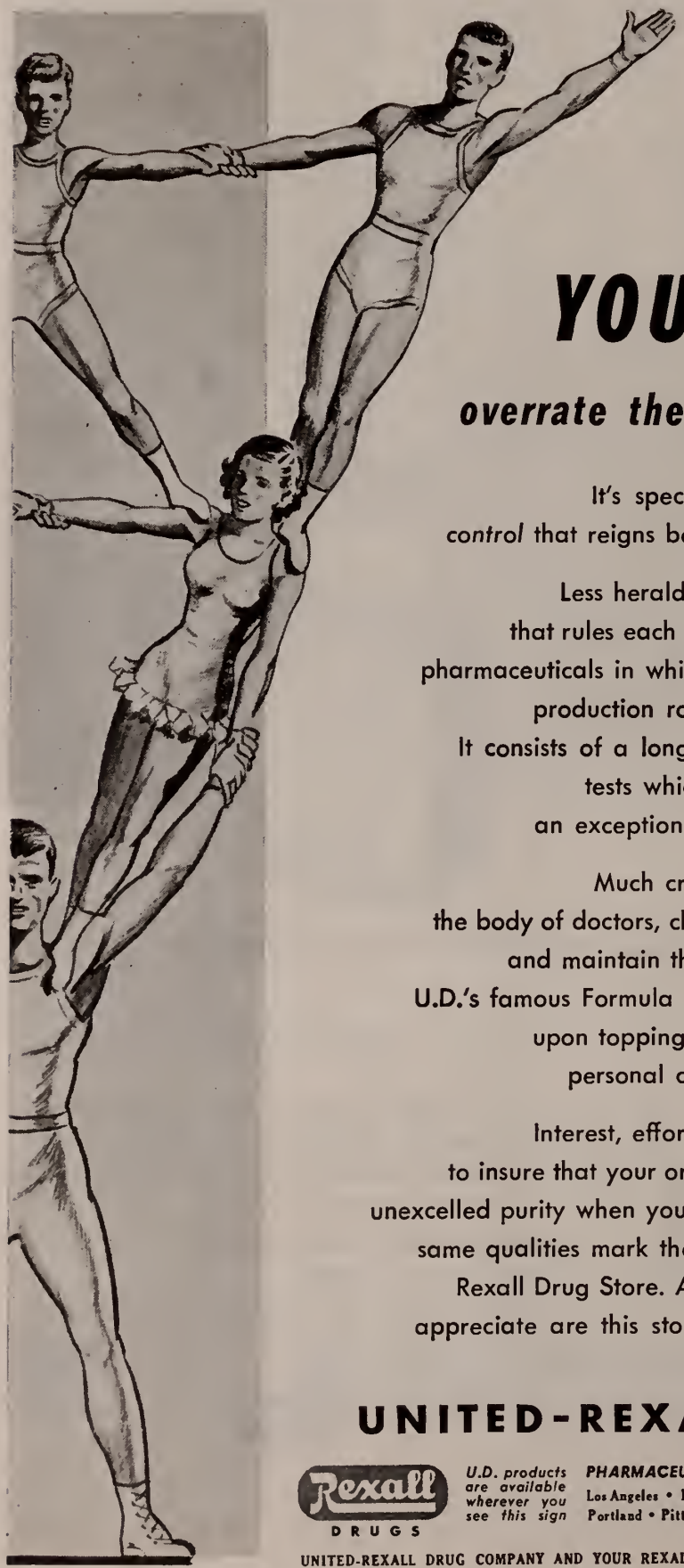
*Prevents spread* of the lesions. The base of kaolin and alumina gel inactivates the irritant fluid in the blisters and dries to form a protective coating which prevents spread.

*Controls itching* promptly through the local anesthetic action of phenol.

*Thyptol* is available in 3 oz. bottles. Apply locally.

Wyeth
REG. U. S. PAT. OFF.

WYETH INCORPORATED • PHILADELPHIA 3, PA.



# YOU CAN'T

## overrate the value of CONTROL

It's spectacular, but brief—the kind of *control* that reigns beneath the big top each Spring.

Less heralded is the day-in day-out control that rules each operation in the manufacture of pharmaceuticals in white-walled U.D. laboratories and production rooms. For this is *quality control.* It consists of a long-established, efficient system of tests which have won for these products an exceptional record for consistent quality.

Much credit for these fine results is due the body of doctors, chemists and pharmacists who set and maintain the high standards. This group is U.D.'s famous Formula Control Committee which insists upon topping all previous precautions with a personal check of every finished formula.

Interest, effort, care and experience combine to insure that your orders are filled with materials of unexcelled purity when you specify U.D. preparations. The same qualities mark the service of your neighborhood Rexall Drug Store. Additional features that patients appreciate are this store's convenience and economy.

**UNITED-REXALL DRUG CO.**

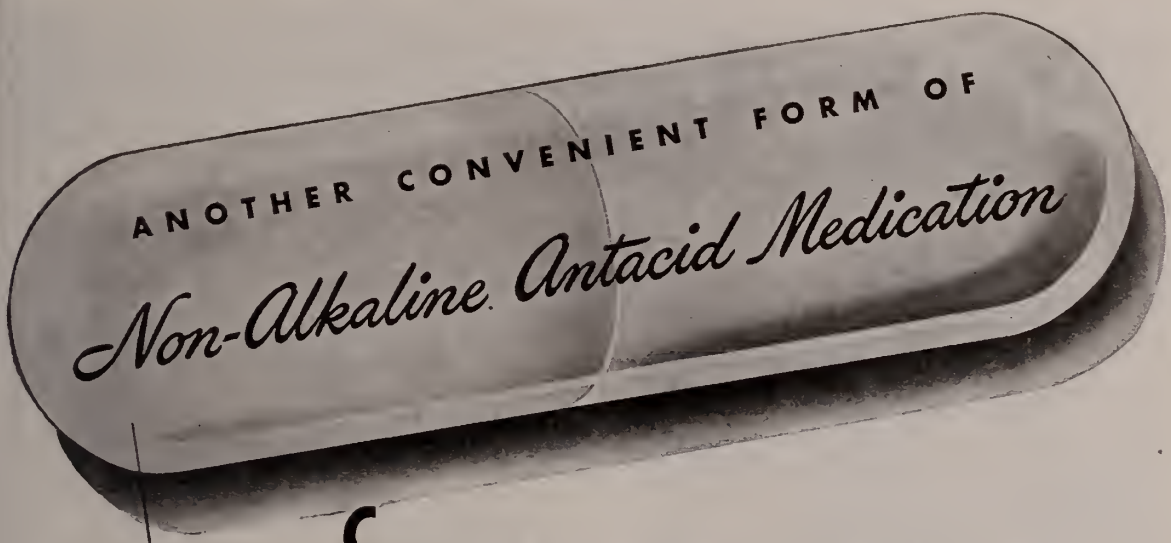
Rexall DRUGS

*U.D. products are available wherever you see this sign*

***PHARMACEUTICAL CHEMISTS FOR MORE THAN 43 YEARS***

Los Angeles • Boston • St. Louis • Chicago • Atlanta • San Francisco
Portland • Pittsburgh • Ft. Worth • Nottingham • Toronto • So. Africa

UNITED-REXALL DRUG COMPANY AND YOUR REXALL DRUGGIST • *Your Partners in Health Service*




Creamalin, the original aluminum hydroxide gel, is now available in capsules, in addition to liquid and tablets.

Creamalin capsules may be swallowed whole or their contents stirred into milk.

Creamalin promptly reduces stomach acidity. Moreover, the antacid effect is sustained. With Creamalin there is no compensatory reaction by the gastric mucosa and no oversecretion of hydrochloric acid. Furthermore, there is no risk of producing alkalosis. Through the formation of a protective coating and a mild astringent effect, nonabsorbable Creamalin soothes the irritated gastric mucosa. Thus it rapidly relieves gastric pain and heartburn, and helps in the healing of peptic ulcers.



# CREAMALIN

Trademark Reg. U. S. Pat. Off. & Canada

*Brand of* Aluminum Hydroxide Gel

*Capsules* in boxes of 24 and bottles of 100 and 1000

**TABLETS**  in bottles of 50, 200 and 1000

**LIQUID** in bottles of 8, 12 and 16 fl. oz. 

*Winthrop* CHEMICAL COMPANY, INC.

*Pharmaceuticals of merit for the physician* • New York 13, N. Y. • Windsor, Ont.

# P. R. N.

The Jocular Jingles of C. G. F.

*by*

*Charles G. Farnum M. D.*
*Peoria, Ill.*

## THE SAGA OF THE GREAT EXHIBIT A

In long past time,
When in his prime,
He was the great Exhibit A:
He did all sorts
Of games and sports,
And in a most efficient way.

In winter he played hockey and was guard in basketball,
He swam in all the swimming meets a smooth Australian crawl.
He played in tennis tournaments where he was seeded three,
He did the hurdles, low and high, and pole vault skillfully;
In sprints and middle distances he made them all look sad,
He broke two all-time records in the sixth Olympiad;
He was an All-American to end his senior year,
But in his catalogue of sports his baseball was most dear.
He'd rather pitch a baseball game, at any time, than eat,
He pitched his team to Championship, perhaps his greatest feat.

So when his college days were done he crashed the Major League,
He'd pitch for eighteen innings and he never knew fatigue,
He faced their toughest batters and he stood them on their ear,
He batted near .300 and he did it year by year.
And then each winter simply for the sake of exercise,
He fought with all the heavy weights regardless of their size.

At last, the old wing faltered and his legs began to fail,
His eyes got somewhat foggy, so he hit the homeward trail.
He sat around and talked baseball, and reveled in his fame,
An idol to his audience — the greatest in the game.
Right soon concerning weight and girth he started in to fuss,
He now resembled very much a hippopatamus.

And then someone suggested he reduce by playing golf,
At which he snorted wildly with a loud and lusty scoff;
But he surrendered finally and bought a set of clubs,
Prepared to demonstrate the game to all the ancient dubs;
To his disgust, astonishment and most supreme surprise,
He couldn't get the swing and all he got was exercise;
He sliced them, hooked them, topped them and they went from side to side,
The fairways were too narrow and the sand traps far too wide;
He tried to hit them easy and he tried to him them hard,
And then he'd get most awful mad and all the rules discard;
He pushed his drives, he scooped his irons, he always stubbed his putts,
His scores were so atrocious that they almost drove him nuts;
He practiced early mornings and at night he practiced late,
With all his careful practice he could never drive them straight;
He changed his grip, he changed his stance, he went to all the pros,
But none of them could teach him how to hit 'em on the nose.

At last he's found a game that has him licked and up a tree,
He's now resigned to be a dub, a dub like you and me.

So Exhibit A
Of by-gone day,
Methinks it more befitting,
That you get off
This game of golf
And take up fancy knitting.

## OLD AND BENT

I find I'm getting older
Life's embers growing colder,
I'm stooped and bent and slowly move about;
Activities I cherished
Long, long ago have perished,
No longer do I laugh or sing or shout.

The thrills of life are banished,
It's pleasures mostly vanished,
I dully sit beside the fire and smoke;
And yet this situation
Has ample compensation,
'Tis better old and bent, then young and broke.

(*Continued on page 52*)

HOW TO PLAN

*Reducing Diets*

EASY FOR PATIENTS TO STICK TO!

**No matter how sound the diet, if a patient won't follow it, it won't work.**

But you *can* plan reducing diets acceptable both to you and the patient. You'll find Knox Gelatine a big help here.

**Knox Gelatine is all protein, no sugar.**

Knox salads and desserts add variety and interest to restricted diets. Many contain high residue, low-calorie foods and so help stave off hunger.

Drinking Knox in water or dilute fruit juices between meals is another good, low-calorie way to combat hunger and make dieting easier.

In diets where supplementary protein is indicated, Knox is of special value.

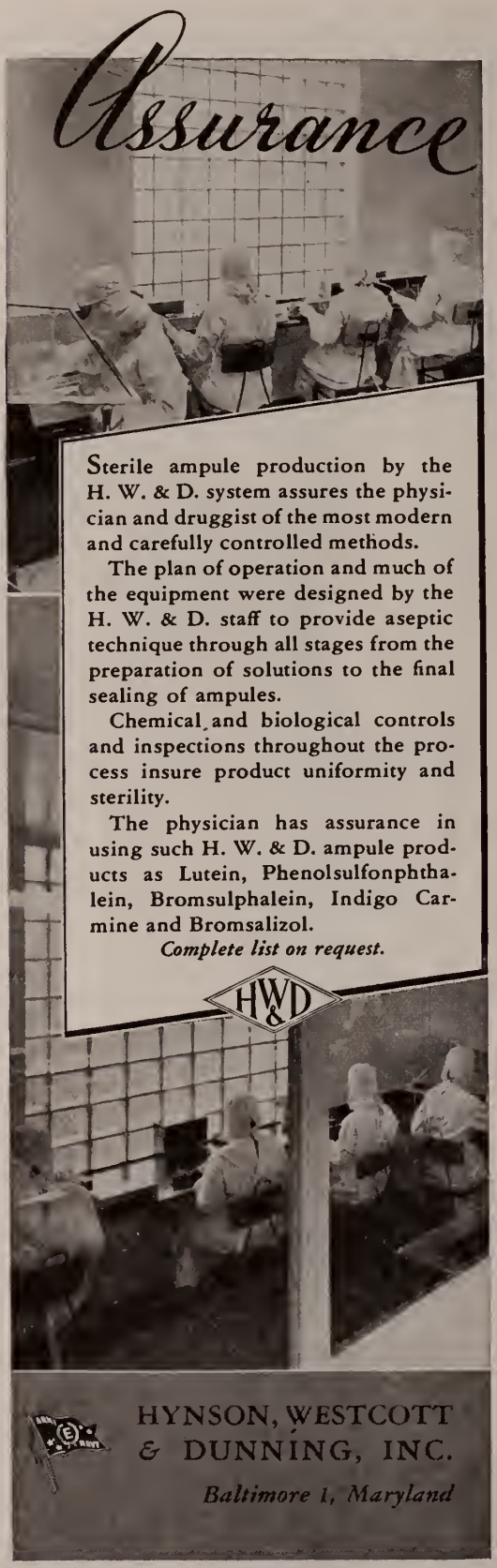
**FREE Diets and Recipes**

*A practical and authoritative booklet containing tables of food values, diet list, sample menu, and delicious, low-calorie gelatine recipes will be sent* FREE *upon request to Knox Gelatine, Johnstown, N. Y.*

**KNOX GELATINE** (U.S.P.)

PLAIN, UNFLAVORED GELATINE...
ALL PROTEIN, NO SUGAR






## P. R. N. (Continued)

### A MILD AND HUMBLE PROTEST

**Disrespectfully dedicated to certain intimate acquaintances whom I hesitate to specify because of my age and physical limitations.**

**The boob that makes me sputter**
**And sizzle and rant and swear**
**And rave and curse and mutter**
**And wildly tear my hair,**
**Is the utterly ignorant moron,**
**The less than half-wit moron,**
**With a brain like clay or an herb,**
**The simpering ignoramus,**
**The untaught ignoramus,**
**The asinine ignoramus,**
**Who uses "contact" as a verb.**

### AD NAUSEUM

There was a time when
I ate prunes at almost every breakfast.
The first course of my dinners
Was pea soup or tomato puree.
Liver, baked or fried, was my favorite meat.
I ate rice,
Both as a cereal and a vegetable.
Everything that cream could be used upon
was drowned in it.
Coffee was my beverage and
Strawberries my favorite dessert.
I ate generously and with relish.

Then I read medical literature.
Therein I learned of prune juice sputum,
Pea soup stools and
Tomato puree vomitus.
Liver-like clots and
Tubercular rice bodies were spoken of.
Creamy pus was everywhere.
Coffee ground vomitus
Was no stranger to its pages.
Many gall bladders resemble strawberries.
Hitherto favorite foods are now nauseating.

My present fear is
That some perverted pseudo-scientist
Will some day find something pathological
That resembles
Corned beef and cabbage.

### QUARRELSOME QUATRAINS

**No doubt our life is drearier**
**Because we are inferior;**
**Yet nothing makes us wearier**
**Than folks who act superior.**

# THIS *Psychic Phase*

## IN HUMAN NUTRITION . . . .



THE feeling of having eaten well, the sigh of contentment that follows a satisfying meal, mean much in human nutrition. The age-old custom of ending the meal with a dessert indicates the importance of satiety value.

Candies serve well as a last course. Even a drab meal leaves a pleasant memory when topped off with a piece or two of candy.

The many kinds of candy in the manufacture of which milk, butter, eggs, fruits, nuts, and peanuts are used, lend themselves particularly well to this purpose. Not only because they are universally liked and appreciated, but also and mainly because they contribute their mite to the satisfaction of many nutritional needs—biologically adequate protein, quickly utilized carbohydrate, fats high in the unsaturated fatty acids, and essential vitamins and minerals.

### THE NUTRITIONAL PLATFORM OF CANDY

**1.** Candies in general supply high caloric value in small bulk.

**2.** Sugar supplied by candy requires little digestive effort to yield available energy.

**3.** Those candies, in the manufacture of which milk, butter, eggs, fruits, nuts, or peanuts are used, to this extent also—

(a) provide biologically adequate proteins and fats rich in the unsaturated fatty acids;

(b) present appreciable amounts of the important minerals calcium, phosphorus, and iron;

(c) contribute the niacin, and the small amounts of thiamine and riboflavin, contained in these ingredients.

**4.** Candies are of high satiety value; eaten after meals, they contribute to the sense of satisfaction and well-being a meal should bring; eaten in moderation between meals, they stave off hunger.

**5.** Candy is more than a mere source of nutriment—it is a morale builder, a contribution to the joy of living.

**6.** Candy is unique among all foods in that it shows relatively less tendency to undergo spoilage, chemical or bacterial.

***This Platform is Acceptable for Advertising in the Publications of the American Medical Association***

COUNCIL ON CANDY OF THE *National Confectioners' Association*

1 NORTH LA SALLE STREET CHICAGO 2, ILLINOIS

# Physical Medicine Abstracts

John S. Coulter, M.D.

## EXERCISES FOR THE CONVALESCENT BED PATIENT

G. Mosser Taylor, M.D., J. Wayne McFarland, M.D., and Anna Bond, Los Angeles
In ARCHIVES OF PHYSICAL MEDICINE,
27;2;89
February, 1946

It is obvious that many convalescents from surgical measures and from disease need absolute rest, but there does come a time when the patient must be encouraged to use the parts not involved by the lesion from which he is recovering. The exercises prescribed usually require modification to fit the physical condition as it has been affected by the disease or operation sustained.

The patient may be weak and consequently unable to put much physical force into the movements, but the frequent effort of going through the motions will result in more perfect re-coordination of mind and muscle. It is therefore all important for the patient to pay strict attention to what he is attempting to do, particularly during the relaxation phase. Only in this way can abnormal tensions be spotted and released.

Medical and surgical complications, such as phlebothrombosis, thrombophlebitis and pulmonary embolism, are best prevented by the use of routine exercises.

Patients are much better conditioned physically on discharge from bed rest if systematized exercises have been carried out.

The basic principles taught in this series of exercises are such that if the exercises are continued indefinitely at home they constitute a simple program of physical conditioning.

A series of twelve exercises is described for the convalescent bed patient.

The rationale for the various groups of exercises is outlined.

## CHOREA

Joseph A. Johnston, M.D., Pediatrician-in-Chief, Henry Ford Hospital, Detroit, Michigan
In THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY,
45;2;204
February, 1946

Treatment

In a disease as variable in severity and duration as chorea, and, in its pure form, carrying with it so small a chance of a complicating carditis, the results of treatment are difficult to evaluate. So striking, however, was the reduction in complications in Sutton and Dodge's follow-up of patients treated with fever induced by triple typhoid vaccine that we have felt it a duty to recommend this to all suitable cases. We have not used it when there was evidence of active carditis. Of twenty-five who received it, five developed carditis, but all of these had joint manifestations of rheumatic fever as well. In a few cases showing evidence of increased intracranial pressure; papilloedema and bradycardia, hypertonic glucose has seemed to have value. *The Kettering hypertherm was tried but discontinued when it seemed to represent an exhausting experience, physically and emotionally.*

We feel that chorea is a mild manifestation of the rheumatic state; that uncomplicated by joint manifestations, the likelihood of carditis is

(*Continued on page* 56)



# *Better results in rheumatoid arthritis*

"Almost all physicians who have had considerable experience with gold therapy in rheumatoid arthritis report better results than can be obtained with other types of therapy."[1]

SOLGANAL-B OLEOSUM, an organic compound containing approximately 50 per cent gold, is first choice with leading rheumatologists since it is both highly effective in controlling the disease and potentially less toxic.

## SOLGANAL-B OLEOSUM

(aurothioglucose)

SOLGANAL-B OLEOSUM, $C_6H_{11}O_5SAu$, is soluble in water, but insoluble in oil. It is supplied as a suspension in oil for intramuscular injection. This permits the active material to be absorbed gradually from the tissues to produce a prolonged effect which is therapeutically desirable. The incidence of severe toxic manifestations is also much diminished. Details concerning mode of administration of SOLGANAL-B OLEOSUM, duration of therapy and precautions necessary may be obtained from the Medical Research Division.

1. Comroe, B. I.: Arthritis and Allied Conditions, Philadelphia, Lea & Febiger, 1944, p. 419.

Trade-Mark SOLGANAL-B OLEOSUM—Reg. U. S. Pat. Off.

SCHERING

*Schering* CORPORATION · BLOOMFIELD · NEW JERSEY

In Canada, Schering Corporation Limited, Montreal

## PHYSICAL MEDICINE ABSTRACTS
(Continued)

small. We feel that the treatment of the active states at present is best accomplished with fever therapy induced by triple typhoid vaccine. We feel that its developement is largely conditioned by a poor nutritional background, and that our chief contribution as physicians lies in our insuring normal nutrition, not only by intelligent provision of the requirements for growth, but also by a careful exclusion of those things which interfere with the utilization of food.

---

## SHORT LEG BACKACHE

John M. Butler, M.D., Hot Springs, South Dakota
In THE JOURNAL LANCET, 66;1;11
January 1946

The symptoms of which these patients complain are many and varied. Pain in some region of the back is the most common and next in frequency is nervousness and easy fatigability. Other complaints are inability to sleep, pains radiating around the chest, pains in the legs and knees, suboccipital head and neck pains and pains in arms and shoulders. Pain of sciatic radiation is frequently encountered. In the past three months seven patients with sciatic pains have been cured by the therapy outlined below.

The short leg is a common cause of muscle inbalance or of the so-called postural imbalance in an apparently otherwise healthy individual.

Many of these patients who come to seek relief from backache can be diagnosed merely by careful observation of their gait and standing habits. In men, one frequently sees that the belt of the trousers does not set parallel with the floor but instead, tips to one side. In women, one hip is more prominent and the hollow of the flank is less on one side. One shoulder is, almost without exception, carried low and if fairly snug clothing is worn, one can notice the scoliosis in the back. In watching these patients walk, it is very easy to notice the heavy step on the short leg side.

In further checking, one will notice that the posterior spinous processes fail to fall in a straight line. As pointed out by Sever, the posterior spinous processes should align under

(*Continued on page 66*)





COUNCIL ACCEPTED

Theocalcin

*for the failing heart*

A Wise Choice of Diuretic
and
Myocardial Stimulant

TIME PROVED - EFFECTIVE ORALLY
EASILY TOLERATED

To reduce edema and diminish dyspnea and to improve heart action prescribe 1 to 3 Theocalcin Tablets (7½ gr. each) t. i. d.

Theocalcin (theobromine-calcium salicylate), Trade Mark, Bilhuber.

BILHUBER-KNOLL CORP. ORANGE NEW JERSEY

# The Common Denominator of Reducing Diets

Whether weight reduction is to be brought about gradually, at the rate of a pound or two per week, or drastically at the rate of a pound per day, all reducing diets must recognize one cardinal requirement: the need for protein of the right quality in the right amount.

Unless biologically adequate protein is supplied in the quantity normally required, the living tissue itself would suffer; tissue repair could not be carried on; hemoglobin regeneration would be impaired; antibody formation would be curtailed; resistance to infectious disease would be lessened, and production of enzymes and hormones would fall below the required level

Lean meat may well be called the common denominator of reducing diets. Its protein content is notably high, and the protein it supplies is of high biologic quality, adequate for every protein need.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

AMERICAN MEAT INSTITUTE

MAIN OFFICE, CHICAGO . . . MEMBERS THROUGHOUT THE UNITED STATES




# Truly, this is America

**the village church...the white picket fence...the broad highways which lead to great cities . . . above all, the homes which breed good citizens.**

AMERICA'S strength is bred in her homes. In thousands of towns and cities, where modest bungalow stands proudly alongside a local showplace, where the well-kept lawn of one merges with its neighbor...here, the roots of good citizenship are deeply planted.

Here, too, strong bodies and good minds are built.

Because it is so American to want the finest, they will get it. In medicine, for instance, American hospitals, American practitioners are the envy of the world. In quiet towns or teeming cities, the skilled hands of healing go about their work of keeping America well.

To the science of Medicine the physician brings his own individual art of healing, for just as no two people are exactly alike, so no two cases of illness are identical.

Thus, the physician must be free and unhampered, so that he may combine the *science* of Medicine, which is for humanity, with the *art* of healing, which is for the individual patient.

At Ciba, in a quiet community of broad streets and pleasant lawns, we produce many of the fine pharmaceuticals used by the medical profession. In modern laboratories, Ciba medical scientists pursue their search for yet newer aids to physicians in their treatment of disease. This, too, is the American way.

**CIBA PHARMACEUTICAL PRODUCTS, INC., SUMMIT, NEW JERSEY**

In Canada: **Ciba Company Ltd., Montreal**

VERTAVIS is a single agent, providing in each tablet 10 CRAW UNITS of the whole, powdered Veratrum Viride. The product is standardized biologically by the Craw Method of Daphnia Magna assay, an Irwin-Neisler research development.

Vertavis in essential hypertension effects a significant fall in blood pressure and relief of predominant symptoms. Clinical tests have been conducted continuously for over two years with few side reactions, however mild. Supplied in bottles of 100, 500, 1000. Literature on request.

IRWIN, NEISLER & CO. Decatur, Illinois



*DEPENDABILITY... the most important quality in a contraceptive*

the extra assurance with every tube of Koromex Jelly

TIME TESTED CLINICAL RECORD




with confidence

prescribe...

**ACTIVE INGREDIENTS:** Boric acid 2.0%, oxyquinolin benzoate 0.02% and phenylmercuric acetate 0.02% in a base of glycerin, gum tragacanth, gum acacia, perfume and de-ionized water.

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**HOLLAND-RANTOS CO., Inc.**

551 FIFTH AVENUE · NEW YORK 17, N. Y.

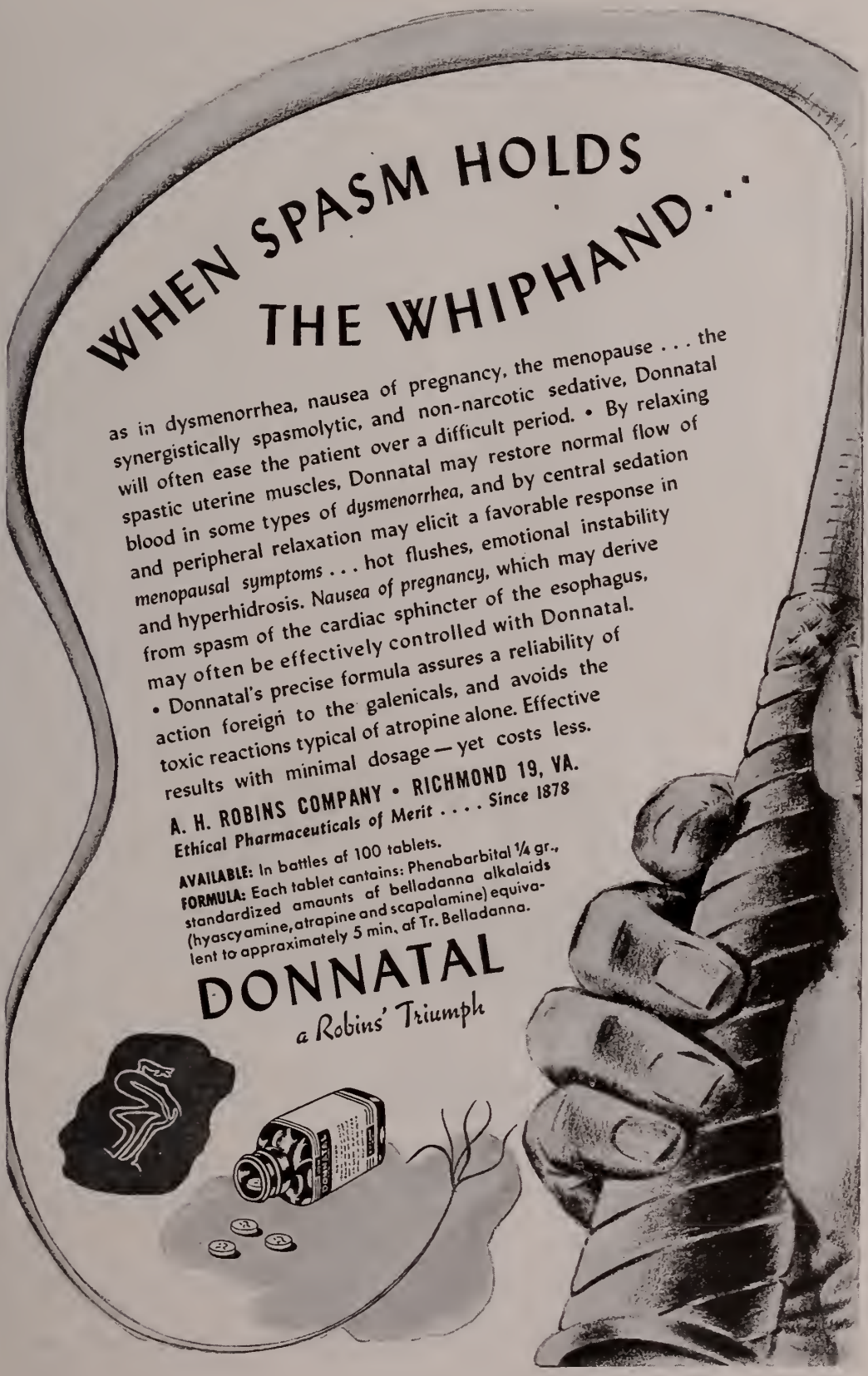
# WHEN SPASM HOLDS THE WHIPHAND...

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## TRENDS INDICATE SPECIALIST IS DISPLACING FAMILY DOCTOR

Two Physicians Lament Lowering Of Prestige Of General Practitioner In Regimented Medicine And Suggest Remedies

Overemphasis on the importance of the specialist and the resultant lowering of prestige of the general practitioner have led two Arkansas doctors to propose a plan to check the trend.

Writing in the June 8 issue of *The Journal of the American Medical Association*, S. A. Thompson, M.D., and S.B. Thompson, M.D., of Camden, suggest that the following steps be taken:

*1. Recognition of the general practitioner by regimented medicine (this includes the medical service of the military services, the Veterans Administration, medical teaching centers, certain industrial medical plans and other similar systems) through:*

A. Staff appointments for general practitioners in teaching centers; B. general practice services in teaching, military and Veterans Administration hospitals; C. perpetuation of the Veterans Administration's system for care of the veteran in his local community with general practitioners participating.

*2. Elimination of causes for criticism of the general practitioner through:*

A. Standardization and improvement of training of general practitioners; B. limitation of the work of the general practitioner to that for which he is adequately trained.

*3. Organization of general practitioners to implement these proposals.*

At present there are some 160,000 practicing physicians, of whom slightly more than 20,000 are certified by the various specialty boards as qualified in their chosen fields. This makes a ratio of one specialist to eight general practitioners.

Some of the examples listed by the authors in illustration of the present trend toward specialization are:

"The Pepper bill now before Congress would perpetuate the maternal and infant care of the Emergency Maternity and Infant Care Program for all families. A committee from the advisory board to the Children's Bureau recommended

(*Continued on page* 64)

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that only certified specialists be allowed to participate in this program. The advisory board did not accept the committee's report, but it is indicative of the trend of thinking now in progress.

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"More and more prominence is being assumed in private practice by the group clinics, and the trend in these appears to be steadily toward specialization."

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"The economic waste involved in specialty care for routine conditions has already been mentioned, but, more positively, what has the general


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practitioner accomplished? During the past 50 years the life expectancy has been increased from 33 to 60 years, maternal and infant mortality has been lowered tremendously, many infectious diseases have been all but eliminated, and numerous other great strides have been made."

Summing up the case for personalized medicine, the physicians say that during the last 40 years "one may safely conclude that well over 90 per cent of medical care to patients has been given by general practitioners. . . . Has the general practitioner not been successful in bringing the advances of medical science to the patient? Surely this implies that he is capable of treating patients."

---

It must be remembered that the returning tuberculosis veteran is, oftentimes, a difficult patient to treat. Because of his military experience he may have undergone personality changes. He has probably suffered the pangs of homesickness and the annoyance of strick military discipline. Add to these factors a diagnosis of tuberculosis and the chances are that we have a thoroughly depressed individual who rebels against the restrictions that are necessary to effect an arrest of his disease. William H. Hickerson, M.D., NTA Bull., Dec., 1945.

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(Continued)

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In men, one cannot as a rule make great changes in heel heights without running into difficulty. Consequently, men are advised to have the shoe on the short leg side half-soled and then make the heel adjustments where the difference is one half inch. When the leg shortness is greater than one half inch, it is better to put more lift on the sole rather than to make too much change in the heels alone.

# Books Received

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

HUMAN EMBRYOLOGY, By Bradley M. Patten, Professor of Anatomy in the University of Michigan Medical School. With 1366 Drawings and Photographs.

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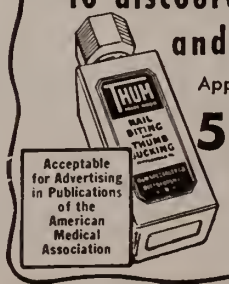
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A Blind Hog's Acorns; Vignettes of the Maladies of Workers; By Carey P. McCord, M.D. With Illustrations by Strobel. Chicago, Cloud, Inc., New York. 1946. Price $2.75.

Current Therapies of Personality Disorders; By Bernard Blueck, M.D., Editor. The Proceedings of the Thirty-fourth Annual Meeting of the American Psychopathological Association, held in New York City, April, 1945. Grune & Stratton, New York, 1946. Price $3.50.

Treatment by Ion Transfer (Iontophoresis); By D. Abramowitsch, M.D., Physician in Charge of the Physiotherapy Department, Lincoln Hospital, New York City, and B. Neoussikine, M.D., Tel-Aviv. Grune & Stratton, New York, 1946. Price $4.50.

A Textbook of Gynecology: By Arthur Hale Curtis, M.D., Professor and Chairman of the Department of Obstetrics and Gynecology, Northwestern University Medical School; Chief of Gynecology Service, Passavant Memorial Hospital, Chicago. Fifth Edition. 755 pages with 455 illustrations, Chiefly by Tom Jones, including 36 in color. Philadelphia and London: W. B. Saunders Company, 1946. Price $8.00.

Through the Stratosphere. The Human Factor in Aviation. By Maxine Davis. The MacMillan Company, New York, 1946. Price $2.75.

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Bombs exploding near a person in the open will not damage the brain or the nervous system, according to a study made by Comdr. Robert S. Schwab, (MC), U. S. N. R., writing in the May 11 issue of *The Journal of the American Medical Association.*

Included in Comdr. Schwab's study are 350 patients observed in the Pacific theatre during 1944 and 1945. They were admitted to naval hospitals with a diagnosis of concussion of the brain. All had been near either a bomb or shell when it exploded.

The author states that over 90 per cent of the so-called air blast concussion cases are psychoneurotic states produced in men by exhaustion and anxiety. "There is no evidence from the observations that I made in these cases of damage to the brain or nervous system."

About 40 per cent of the men studied by the author complained of amnesia lasting anywhere from 30 minutes to 30 hours. It is this amnesia which has led to the belief that the brain is damaged. However, the amnesia occurred after the patient had heard the explosion and felt himself pushed down by its effect. In all cases in which drugs and hypnosis were used the memory was restored.

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VOL. 90 NO. 2

August, 1946

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Corrective Surgery of the External Nasal Pyramid

Pictorial Report on the 1946 Annual Meeting

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signifying exclusive application to the field of Professional Protection . . . . assuring special knowledge and skill in the science of protection against malpractice charges to those we serve.

★

*We Lead Because We Specialize*

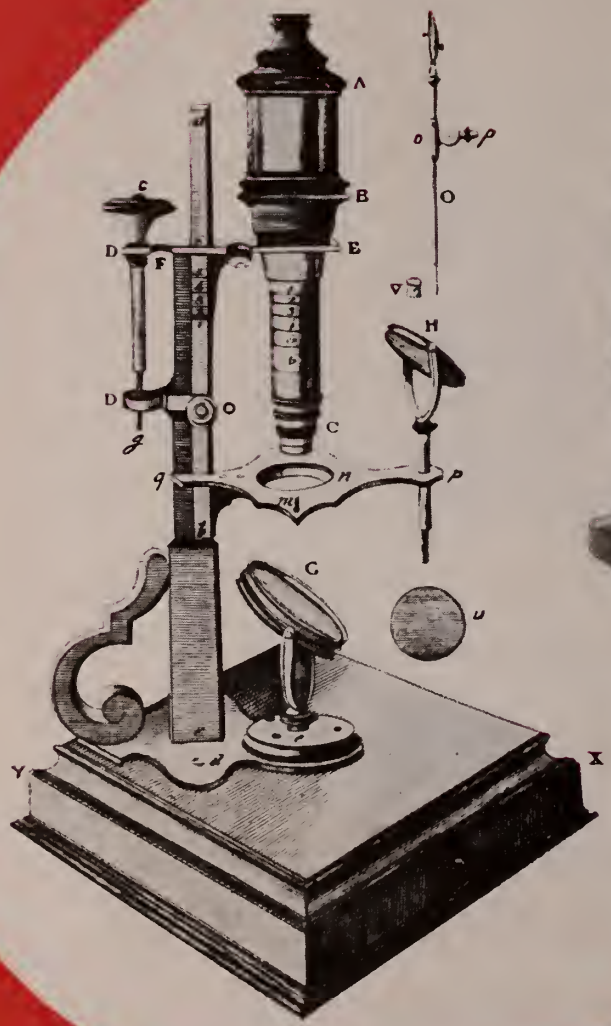
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THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

# demonstrably superior in






White

White's

LABORATORIES, INC. Pharmaceutical Manufacturers, Newark 7, N. J.

# treatment of hypochromic anemias

**Since the discovery of the microscope, years of research and patient effort have been spent in producing the modern magnificent instrument—a diagnostic aid and a guide to therapeusis of recognized demonstrable superiority.**

In treatment of hypochromic (so-called "secondary") anemias Mol-Iron therapy—as compared to equivalent dosage of ferrous sulfate alone—achieves these strikingly superior clinical results:

1. Normal hemoglobin values are restored more rapidly, increases in the rate of hemoglobin formation being as great as 100% or more in patients studied.
2. Iron utilization is similarly more complete.
3. Gastro-intestinal tolerance is excellent—even among patients who have previously shown marked gastro-intestinal reactions following oral administration of other iron preparations.

White's Mol-Iron is a *specially processed*, co-precipitated complex of molybdenum oxide 3 mg. (approx. 1/20 gr.) and ferrous sulfate 195 mg. (3 gr.).

*In bottles of 100 and 1000 tablets.*

# Mol-iron *Tablets*

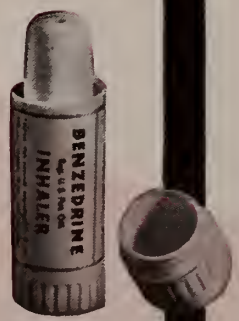
*Benzedrine Inhaler, N.N.R.*
*"... is quite effective in the clearing of nasal congestion due to allergy or infection"*

Feinberg, S. M.: Allergy in Practice,
Chicago, The Year Book Publishers, Inc., 1944, p. 502.

Your hay fever patients will be grateful...particularly between office visits...for the relief of nasal congestion afforded by Benzedrine Inhaler, N. N. R.

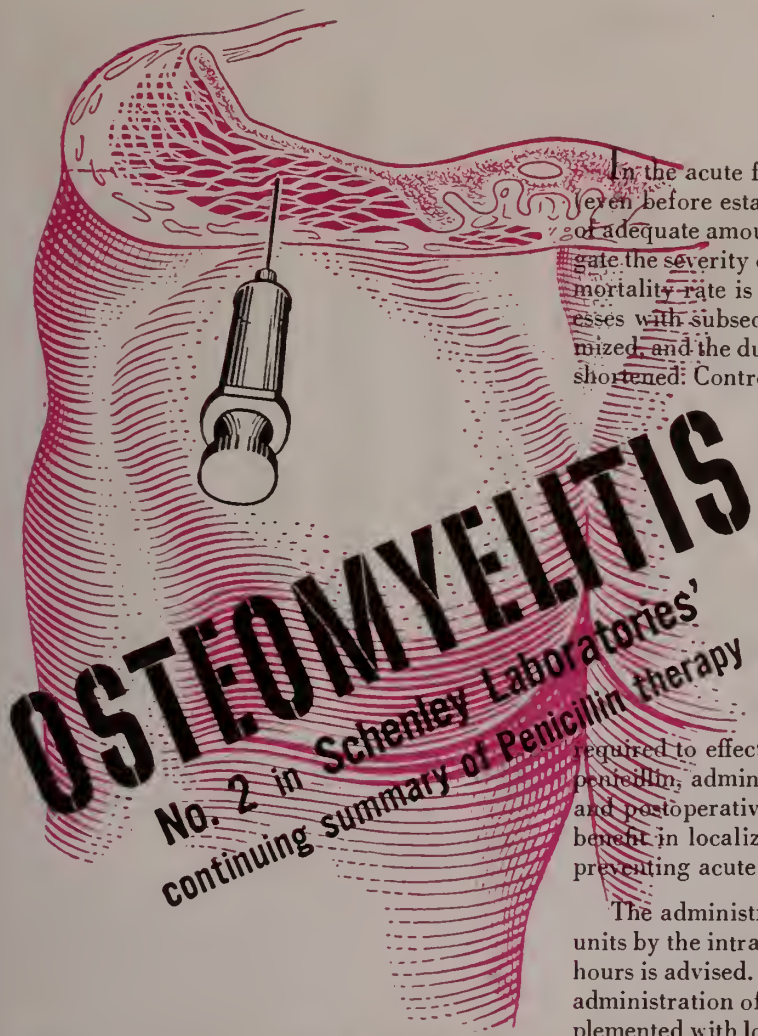
The Inhaler may make all the difference between weeks of acute misery and weeks of comparative comfort.

Each Benzedrine Inhaler is packed with racemic amphetamine, S.K.F., 250 mg.; menthol, 12.5 mg.; and aromatics.




Benzedrine Inhaler
*a better means of nasal medication*

Smith, Kline & French Laboratories, Philadelphia, Pa.



# OSTEOMYELITIS

## No. 2 in Schenley Laboratories' continuing summary of Penicillin therapy

In the acute form, early administration (even before establishment of the diagnosis) of adequate amounts of penicillin will mitigate the severity of the infection. Hence, the mortality rate is reduced, destructive processes with subsequent deformity are minimized, and the duration of the disease is shortened. Control and eradication of the infection may be obtained without major surgical intervention; however, surgical removal of necrotic bone will be required in some instances and abscesses should be either aspirated or incised and drained.

In the chronic form, major surgery is usually required to effect a cure; however, penicillin, administered both preoperatively and postoperatively, is of inestimable benefit in localizing the infection and preventing acute exacerbations.

The administration of 20,000 to 40,000 units by the intramuscular route every 2 to 4 hours is advised. When necessary, parenteral administration of penicillin should be supplemented with local instillations of 25,000 to 50,000 units in a sterile solution two to three times daily. Due attention must be paid to surgical, supportive, and other measures when these are indicated.

To determine complete control and eradication of the infection, a prolonged follow-up period with frequent physical examinations and serial roentgenograms is advised.

---

KEEFER, C. S. *Penicillin—Its Present Status in the Treatment of Infections: The Nathan Hatfield Lecture XXIX, Am. J. Med. Sc. 210:147 (Aug.) 1945.*

ALTEMEIER, W. A.: *Treatment of Acute Hematogenous Osteomyelitis with Penicillin, Ohio State M. J. 42:489 (May) 1946.*

**BEFORE YOU DECIDE ON THE PENICILLIN OF YOUR CHOICE**

For many years, Schenley has been among the world's largest users of research on mycology and fermentation processes. In addition, Schenley Laboratories manufactures a complete line of superior penicillin products—products thoroughly tested for potency and quality. These two important facts mean you may give your patients the full benefits of complete penicillin therapy.

**SCHENLEY PENICILLIN PRODUCTS**

Penicillin Ophthalmic Ointment Schenley
Penicillin Ointment Schenley
Penicillin Troches Schenley
Penicillin Tablets Schenley
Penicillin Schenley

**SCHENLEY LABORATORIES, INC.** Executive Offices: 350 Fifth Avenue, N. Y. C.

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for New and Nonofficial Remedies by the Council on Pharmacy and Chemistry of the American Medical Association.




## PERTUSSIS ENDOTOXOID-VACCINE

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

**Bacterial Vaccine and Bacterial Antigen Combined.**
Made from H. pertussis phase I organisms.

**Ayerst Pertussis Endotoxoid-Vaccine is made by suspending H. pertussis phase I organisms in a formalized endotoxin solution prepared from H. pertussis phase I. The resulting Pertussis Endotoxoid-Vaccine is both antibacterial and antiendotoxic, thus providing immunity to the H. pertussis organisms and to the endotoxin produced by these organisms.**

**Ayerst Pertussis Endotoxoid-Vaccine is available in vials of 6 cc. and 24 cc.**

Ayerst

**AYERST, McKENNA & HARRISON Limited, 22 East 40th Street, New York 16, N. Y.**

# *Confident of Recovery*

The patient's confidence in his own speedy recovery is enhanced greatly when the physician can extend the hours of relief from peptic ulcer pain. And since emotional security is a *sine qua non* in the modern therapy of peptic ulcer, LUDOZAN'S prolonged buffering activity is being relied upon increasingly to obtain long-lasting relief. Consisting of hydrated sodium aluminum silicate, LUDOZAN Tablets and LUDOZAN Powder drive excess gastric acidity back to physiological pH and *keep it there for many hours.*



# LUDOZAN

## *long-lasting antacid*

LUDOZAN TABLETS contain 1 gram hydrated sodium aluminum silicate; boxes of 24, 60 and 250 tablets. LUDOZAN POWDERS contain 3 grams hydrated sodium aluminum silicate, in single-dose envelopes: boxes of 21 envelopes. When additional antisecretory and antispasmodic effect is desired, prescribe LUDOZAN Tablets with Belladonna containing alkaloids equivalent to gr. 1/12 extract of belladonna; or LUDOZAN Powder with Belladonna containing alkaloids equivalent to gr. 1/4 extract of belladonna.

Trade-Mark LUDOZAN—Reg. U. S. Pat. Off.

SCHERING

*Schering* CORPORATION · BLOOMFIELD, N. J.

IN CANADA, SCHERING CORPORATION LIMITED, MONTREAL




THE sharp seasonal rise in pruritic affections during the warm months is due to a number of factors. Increased perspiration and tissue maceration, contact with allergenic plants such as ivy and oak, ingestion of heat-spoiled food and subsequent intoxication, all contribute their share. In the treatment of these affections, relief of the associated severe itching must be quickly accomplished. For this purpose, Calmitol enjoys a unique position. It stops itching promptly and for prolonged periods, regardless of cause. It enhances the efficacy of other indicated therapy, since it quickly restores emotional quiet and alleviates the need for scratching, thus preventing secondary traumatic lesions. Calmitol provides specific antipruritic action in ivy and other plant poisonings, urticaria, eczema, dermatitis medicamentosa, ringworm, prurigo and intertrigo, and pruritus ani, vulvae, scroti, and senilis.

Calmitol stops itching by direct action upon cutaneous receptors and end-organs, minimizing transmission of offending sensory impulses. The ointment is bland and nonirritating, can safely be applied to any skin or mucous membrane surface. Active ingredients: camphorated chloral, menthol, and hyoscyamine oleate. Calmitol Liquid, prepared with an alcohol-chloroform-ether vehicle, should be used only on unbroken skin areas.

**CALMITOL**

*THE DEPENDABLE ANTI-PRURITIC*

*Thos. Leeming & Co. Inc.*

**155 East 44th Street, New York 17, N. Y.**




# Council Accepted

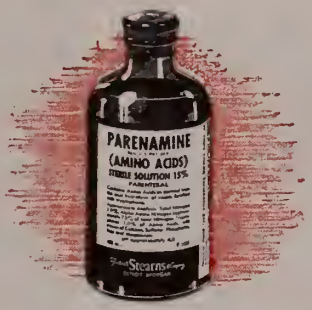
Parenamine, Amino Acids Stearns, an acid hydrolysate developed and perfected by Stearns Research... A sterile, pyrogen-free solution of *all the amino acids* known to be indispensable to humans.

Extensive clinical use* has established the value of Parenamine in preventing and correcting hypoproteinemia and maintaining positive nitrogen balance.

# Parenamine

## Parenteral Amino Acids

## *For Protein Deficiency*




**COMPOSITION:** Derived from casein by acid hydrolysis and fortified with pure *dl*-tryptophane, Parenamine is a sterile 15 per cent solution of all the amino acids known to be essential for humans.

**INDICATED** in conditions of restricted intake, faulty absorption, increased need, or excessive loss of proteins—as in preoperative and postoperative management, extensive burns, delayed healing, gastro-intestinal disorders, fevers, et cetera.

**ADMINISTRATION** may be intravenous, intrasternal, or subcutaneous.

**SUPPLIED** in 100 cc. rubber-capped bottles.

**Reprints and complete clinical data on request.*

Frederick Stearns & Company
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DETROIT 31, MICHIGAN

NEW YORK KANSAS CITY SAN FRANCISCO WINDSOR, ONTARIO SYDNEY, AUSTRALIA AUCKLAND, NEW ZEALAND

Trade-Mark *Parenamine* Reg. U. S. Pat. Off.




Postoperative distention and urinary retention may occur despite the most skilful surgical technic. Fortunately, the severe distress of "gas pains," discomfort of catheterization, and the need for enemas and symptomatic therapy may be obviated—and the patient afforded a smoother convalescence—by parenteral administration of one ampul (1 cc) of Prostigmin Methylsulfate* 1:4000 at the time of operation, repeated at 2-hour intervals for a total of 6 injections. Recognition of this fact by leading surgeons has made the prophylactic use of Prostigmin a routine measure in many hospitals.

HOFFMANN-LA ROCHE, INC., Roche Park, Nutley 10, New Jersey

*Neostigmine Methylsulfate

*Prostigmin* 'ROCHE'

# The LONG and the SHORT of FALL HAY FEVER



By far the commonest cause of the autumnal variety of hay fever is the pollen of either or both giant and short ragweed. To meet the needs of some 98% of all fall hay fever sufferers, Pitman-Moore Company offers:

## ALLERGENIC EXTRACT RAGWEED POLLENS
(Mixed)
### *For Individualized Treatment*

★ ***PITMAN-MOORE*** Ragweed Pollen Extract is presented in a specially designed individual treatment package, which permits the dosage to be adjusted to individual sensitivity, a method definitely better than giving every patient the same dosage. The stability of this allergen is intensified by the use, in its production, of a special glycero-saline menstruum which insures full potency beyond the expiration date.

● ***PROPHYLAXIS*** — Injections may be started 3 weeks or more before expected first symptoms.

● ***CO-SEASONAL TREATMENT*** — Applicable following or in lieu of pre-seasonal prophylaxis.

*For more detailed informotion as to od-vontoges, dosoge, etc., write for literoture.*

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

**PITMAN-MOORE COMPANY**

PHARMACEUTICAL AND BIOLOGICAL CHEMISTS

*Division of Allied Laboratories, Inc., · Indianapolis 6, Indiana*



*Kapseals* CARBRITAL

**AN EFFECTIVE HYPNO-SEDATIVE WITH MINIMUM SIDE EFFECTS**

For oral administration in conditions in which it is desirable to obtain the hypnotic action of pentobarbital sodium and the sedative effect of carbromal. Acts rapidly, inducing quiet, restful sleep from which the patient awakens feeling refreshed and alert.

Each CARBRITAL KAPSEAL contains: Pentobarbital Sodium 1½ grains, Carbromal 4 grains.

PARKE, DAVIS & COMPANY
DETROIT 32
MICHIGAN



# Heptuna

**presents a convenient and effective means of rapidly correcting hypochromic anemia and its associated multiple nutritional deficiencies, whether caused by inadequate food intake, increased requirement or by blood loss.**

**EACH CAPSULE CONTAINS:**

| | |
|---|---|
| Ferrous Sulfate U.S.P. | 4½ Grains |
| Vitamin A (Fish-Liver Oil) | 5,000 U.S.P. Units |
| Vitamin D (Tuna-Liver Oil) | 500 U.S.P. Units |
| Vitamin $B_1$ (Thiamine Hydrochloride) | 2 mg. |
| Vitamin $B_2$ (Riboflavin) | 2 mg. |
| Vitamin $B_6$ (Pyridoxine Hydrochloride) | 0.1 mg. |
| Calcium Pantothenate | 0.333 mg. |
| Niacinamide | 10 mg. |

Together with a Liver Concentrate (Vitamin fraction) derived from 6.5 Gm. fresh liver and dried yeast




For the speedy correction of the anemia syndrome and its associated multiple nutritional deficiencies, iron alone is usually inadequate. *All* the lacking essential nutrients must be supplied, by both diet and appropriate medication.

*Supplied in boxes of 50 and 100 capsules.*

**J. B. ROERIG & COMPANY**

**536 Lake Shore Drive, Chicago 11, Illinois**




# milk TABOO?

Milk intolerance in adults may frequently be a cause of gastro-intestinal upsets, migraine, urticaria, etc., which may place milk on the "taboo" list.

For such patients the easy digestibility and high nutritive value* of MULL-SOY make it an ideal milk substitute... by providing a rich source of all essential amino acids in the form of soy proteins, together with the other nutritional values of fat, carbohydrate and minerals in quantities closely resembling those of cow's milk when mixed in standard dilution (1:1).

*Cahill, W M, Schroeder, L. J. and Smith, A. H Digestibility and biological value of soybean protein in whole soybeans, soybean flour, and soybean milk, J. Nutrition, 28.209, Sept. 1944.

**BORDEN'S PRESCRIPTION PRODUCTS DIVISION, NEW YORK**
IN CANADA WRITE THE BORDEN COMPANY, LIMITED, SPADINA CRESCENT, TORONTO




Literature containing "Tasty recipes for Mull-Soy in milk free diets" will be gladly sent on request.

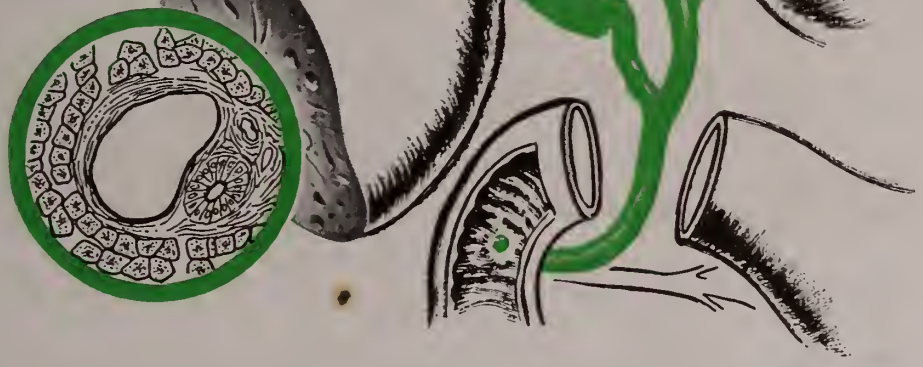
## WHEN MILK BECOMES FORBIDDEN FOOD MULL-SOY

MULL-SOY is a liquid emulsified food prepared from water, soy flour, soy oil, dextrose, sucrose, calcium phosphate, calcium carbonate, salt and soy lecithin. Homogenized and sterilized. Available 15½ fl. oz. cans at all drug stores.

ANOTHER SIGNIFICANT CONTRIBUTION BY MALTBIE RESEARCH CHEMISTS

*Announcing* **CHOLANOX**

A COMBINATION OF KETOCHOLANIC ACIDS AND DEHYDRATED WHOLE OXBILE . . .



THE PHYSIOLOGICAL APPROACH TO THE MANAGEMENT OF

**BILIARY DISEASE . . .**

**HYDROCHOLERESIS** A mixture of ketocholanic acids (approximately 90% dehydrocholic acid) to combat biliary stasis by increased production of free flowing bile.

**BILE SALT REPLACEMENT** Dehydrated bile for the efficient digestion of fats, absorption of vitamins and minerals and to stimulate intestinal motility.

**SUPPLIED:** In orange-coated tablets in bottles of 100, 500 and 1000 each containing 1¾ gr. ketocholanic acids and 1¾ gr. oxbile dehydrated.

*Complete literature on request.*

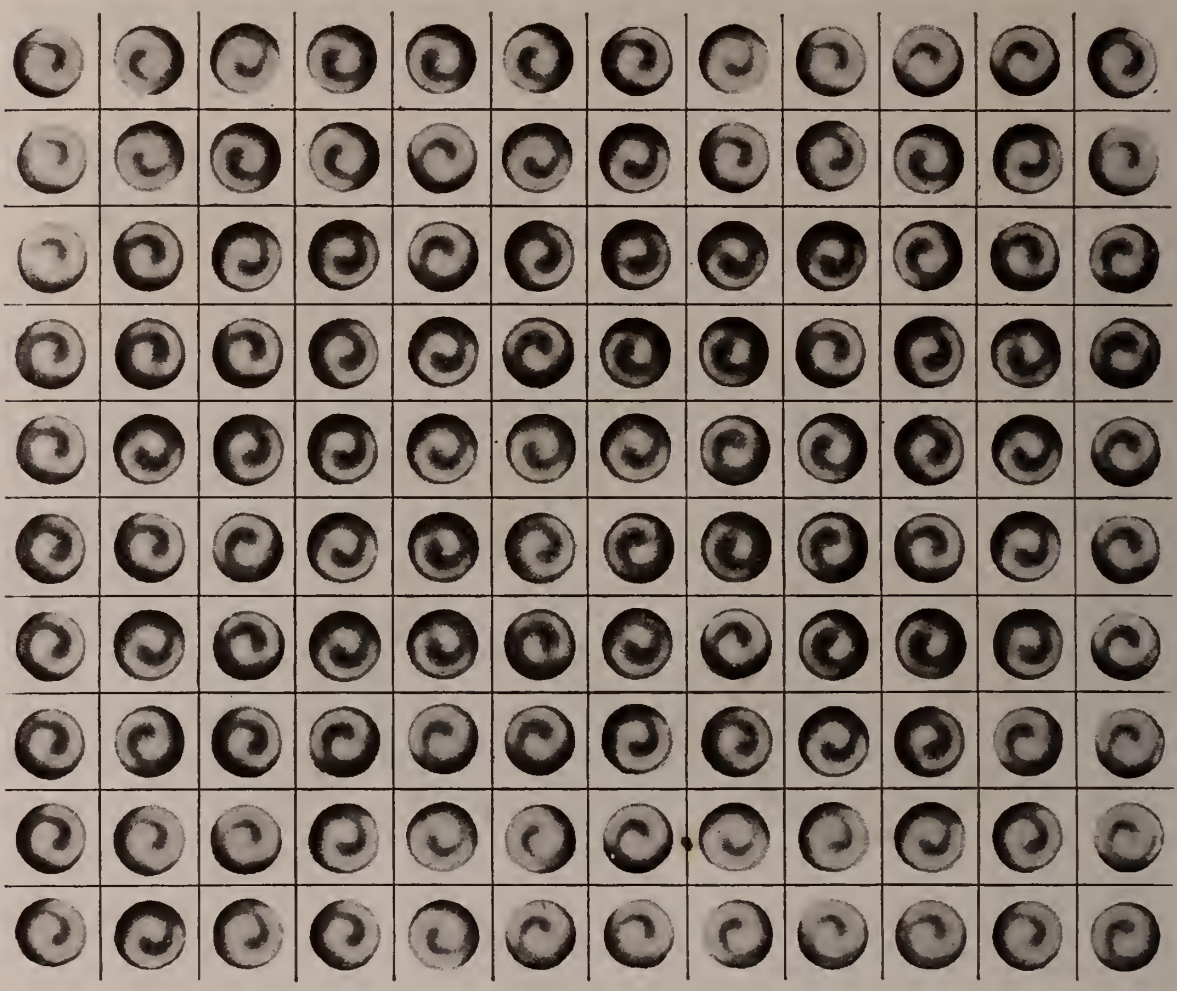
*Cholanox*

**THE MALTBIE CHEMICAL COMPANY**

*Founded in 1888*

NEWARK, N. J.

FOR BETTER MEDICAL MANAGEMENT OF BILIARY DISEASE



## a normal R.B.C. lives 120 days*

Although the four month span of the normal erythrocyte may be considerably shortened during anemic states, the physician can lengthen this pathologically curtailed life by appropriate therapy. 'Tabloid' 'Ferad' No. 2, a clinically proved agent for the treatment of iron-deficiency anemias, contains the most effective therapeutic form of iron—ferrous sulfate (Ferrous Sulfate, Anhydrous gr. 2-3/5) combined with enough sodium carbonate (Sodium Carbonate, Anhydrous gr. 1-4/5) to assure optimal gastric tolerance.

*Callender, S. T. J. Path. & Bact. 57:129, January 1945

**'Tabloid' 'FERAD' No. 2**

BOTTLES OF 100 AND 500...'Tablaid' and 'Ferad' Registered Trademarks

BURROUGHS WELLCOME & CO. (U.S.A.) INC. 9-11 EAST 41ST ST., NEW YORK 17, N.Y.



Final stage in the purification of penicillin—the removal of pyrogens by filtration of the penicillin concentrate.

# A GLIMPSE AT THE RECORD

**IN 1940** Merck research on antibiotics concentrated on Penicillin.

**IN 1941** Merck brought about a reciprocal arrangement between British and American investigators to spur the production of Penicillin in co-operation with the United States and British governments.

**IN 1942** Merck supplied Penicillin for the first case of bacteriemia successfully treated with this drug in the United States.

**IN 1943** Merck sent shipments of Penicillin to England by air transport for urgent therapeutic use by the United States Army Medical Corps.

**IN 1944 AND 1945** Merck produced ever-increasing supplies of Penicillin for our Armed Forces.

**AND NOW,** Merck production of Penicillin has reached a point where large quantities of high-quality Penicillin are being produced for civilian medical needs.




★ ★ ★

Penicillin Merck meets the recognized high standard of quality established for all Merck products. It is subjected to repeated tests and control procedures throughout every step of the production process, and the finished product is assayed, tested, and approved under rigid standards established by the Food and Drug Administration and by the Merck Analytical Laboratories.

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PENICILLIN
MERCK

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*Literature on request*

**MERCK & CO., Inc.** *Manufacturing Chemists* **RAHWAY, N. J.**

# Take Penicillin to the Site of Infection




When your diagnosis indicates the presence of staphylococci or streptococci in surface lesions, you will find an effective weapon in the form of Bristol Penicillin Ointment Dermatologic.

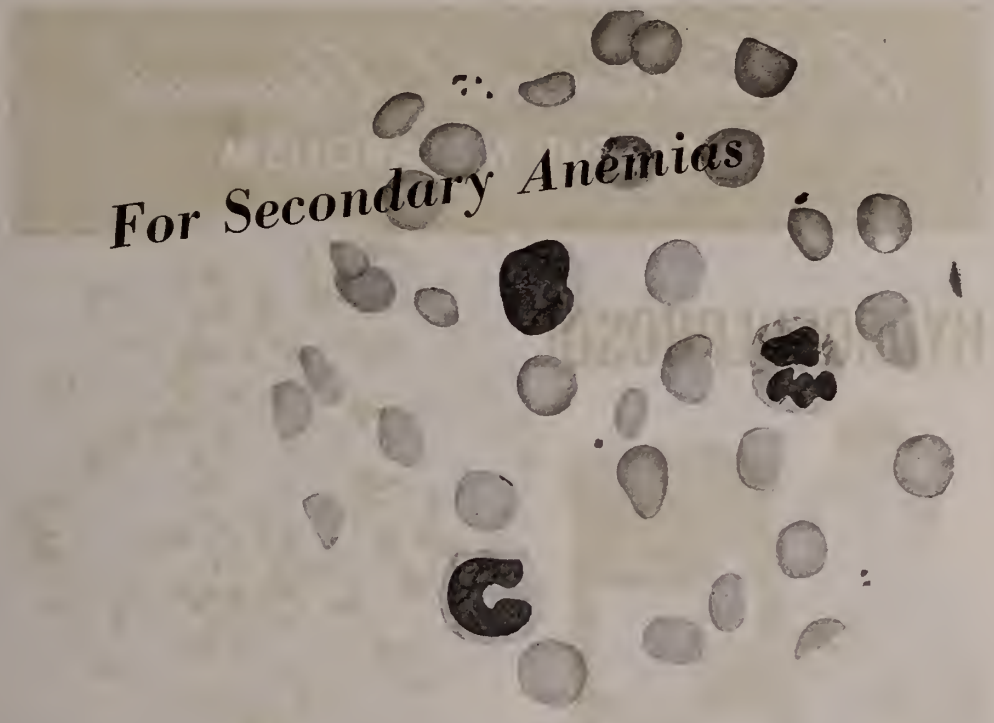
The product contains 1,000 units of penicillin per gram, incorporated in a suitable base. The penicillin is held in contact with the infected area for a prolonged period of time. The uniform diffusion of the antibiotic from the base insures sustained release, for maximum therapeutic effectiveness.

Bristol Penicillin Ointment Dermatologic is available in half-ounce tubes. Your pharmacist can supply your prescription requirements.

## BRISTOL PENICILLIN OINTMENT *Dermatologic*

BRISTOL
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SYRACUSE 1, NEW YORK




Campobiol is a therapeutically effective, potent, well tolerated combination of vitamin B complex factors with liver concentrate and iron. Marketed in easy-to-swallow gelatin capsules, with a pleasing aromatic odor.

EACH CAPSULE CONTAINS

| | |
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| Thiamine hydrochloride (vitamin $B_1$) | 2 mg. |
| Riboflavin (vitamin $B_2$) | 2 mg. |
| Nicotinamide | 10 mg. |
| Ferrous sulfate (anhydrous) | 100 mg. |
| Liver concentrate (1 to 20) | 200 mg. |

Prophylactic dose for adults: 1 capsule daily. Therapeutic dose for adults: 2 or 3 capsules three or more times daily, depending on severity of the anemia.

**Campobiol**
TRADE MARK

Brand of
Vitamin B COMPLEX Factors
with LIVER Concentrate and IRON

SUPPLIED IN BOTTLES OF 50 AND 200 CAPSULES

WINTHROP CHEMICAL COMPANY, INC.
Pharmaceuticals of merit for the physician • New York 13, N. Y. • Windsor, Ont.

*A Fundamental Approach*

TO SULFUR METABOLISM

# HYDROSULPHOSOL



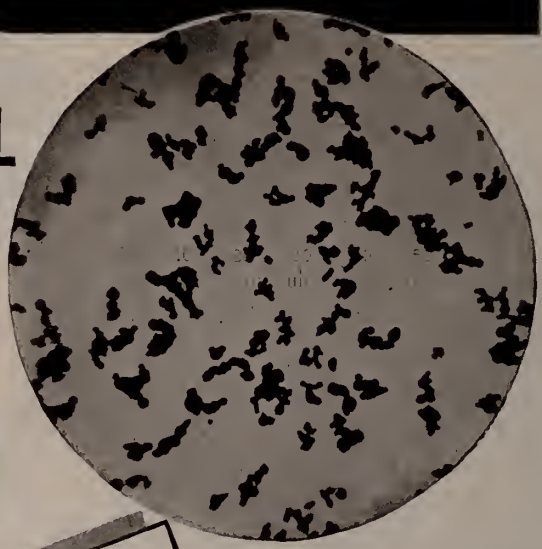



*Illustration showing flowers of sulfur magnified 82X: small divisions = 10 microns. The size of the colloidal sulfur particle in Hydrosulphosol is estimated at 1/1000 of a micron or 1/10,000 of the small division particle illustrated.*

A true solution of sulfur bearing compounds resulting solely from the reduction of flowers of sulfur by a catalytic process. In aqueous solution, it is capable of releasing its unusually high concentration of sulfhydryl ion in readily utilizable form . . . without evidence of toxic reaction.

Its therapeutic importance may best be evaluated by the fact that the —SH radical of the cysteine forms the active group in glutathione, alone of reported importance in connection with tissue oxidations.

Hydrosulphosol is indicated in the management of burns, ulcers and pathological conditions in which sulfur metabolism is a clinical consideration.

*Reprints of scientific papers by authoritative investigators available on request.*

*Rees-Davis Drugs, Inc.*

MERIDEN, CONNECTICUT

# THE MALE CLIMACTERIC

"We urge the careful study of men from 50 to 65"



"The complete disappearance of manifestations in the male climacterium is so prompt following testosterone therapy that this response may be used as a simple therapeutic test to differentiate complaints of this nature from those of other causation."

(Galdman and Markham: Jl. Clin. Endocrin., 2: 237, 1942.)

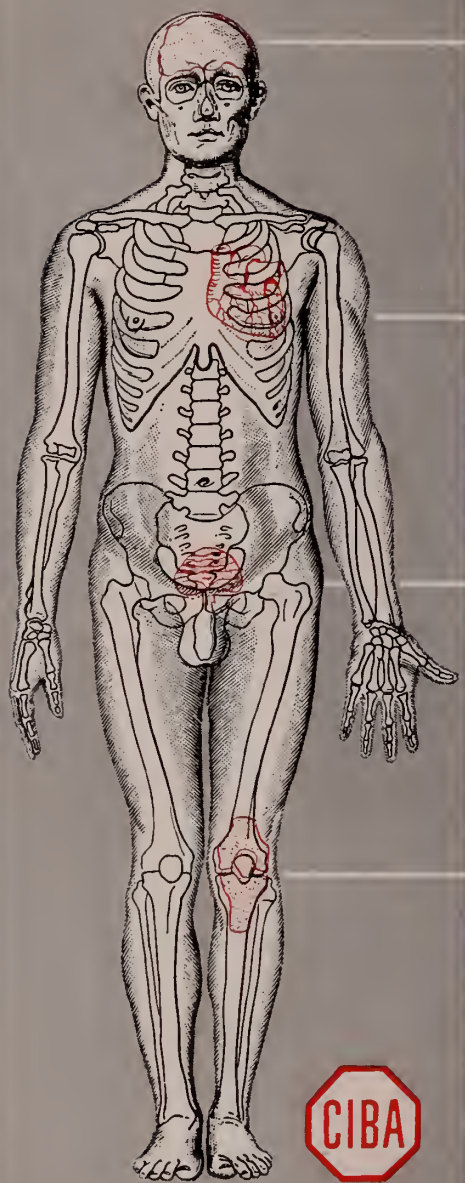
## *Perandren*

(TESTOSTERONE PROPIONATE)

Perandren, pioneer brand of synthetic testosterone propionate offered to the American medical profession, is still unsurpassed in potency and in therapeutic effect.

CIBA

# "THE SYMPTOMS OF THE CLIMACTERIUM MAY BE GENERAL..."[2]



**PSYCHIC**—Symptoms of the climacterium in the male may include general mental depression and inertia, nervousness, irritability and irascibility. Inability to concentrate and impaired memory are accompanied by a feeling of uncertainty.[2,3]

**CARDIAC**—Attacks of angina-like pain which are not necessarily related to effort or to the time of night or day, and which are not relieved by nitroglycerine, are a clinical feature by which the cardiac syndrome in the male climacterium may be recognized.[2]

**GENITO-URINARY**—Mild urinary symptoms, including loss of force of the urinary stream, terminal dribbling, vague lower abdominal distress, are commonly found. Decrease of libido and potency may or may not be an accompaniment of other symptoms.[2,3,4,5]

**ARTHRALGIC AND MYALGIC**—Symptoms include shifting neuralgic pains in the legs and arms, paresthesias of various parts of the body, varying from a feeling of numbness to lightning-like pain and distinguished by their fleeting nature and tendency to migrate.[2,3]

CIBA

Androgens promptly relieve climacteric symptoms

## PERANDREN

The syndrome of the climacteric, with its multiplicity of symptoms, responds promptly to therapy with Perandren: chemically pure testosterone propionate in ampuls for injection. Administered in adequate quantity, Perandren usually brings about abatement of symptoms in a period of from 48 hours to three weeks. It is considered advisable to continue therapy for at least six weeks in the event that treatment is being instituted to clarify a doubtful diagnosis. Suggested dosage: 10-25 mg. two to three times weekly, depending upon the severity of symptoms and the patient's response to therapy.

## METANDREN LINGUETS

Results clinically identical to those secured with Perandren may be obtained by therapy with Metandren Linguets: hard pressed wafers of methyltestosterone which are not swallowed but allowed to remain under the tongue or in the cheek until completely dissolved. According to Lisser and Curtis[6] "Methyl testosterone linguets in the form of hard pressed tablets for sublingual absorption, is to date, by far the most economical mode of administering androgens to hypogonad males." Many physicians find it advisable to begin therapy with injections of Perandren and to maintain the patient with Metandren Linguets. Maintenance dosage in the climacteric is usually one Linguet three times daily.



## THE MALE HORMONE IN BREAST CARCINOMA

The use of testosterone propionate in carcinoma of the female breast has received much attention of late. It has been reported that in some cases dramatic relief of symptoms has been achieved with this type of therapy. Retardation of growth and even regression of the metastases appear to take place in some instances, although the ultimate outcome remains unaffected. Indications point to advisability of high dosages, regardless of virilization.

# STEROID ANDROGENIC HORMONES FOR DURATION OF EFFECT WITH ECONOMY




## PERANDREN

(testosterone propionate)

### AMPULS FOR INJECTION

The most potent ondrogen ovoiloble. Ampuls of one cc. contoining 5, 10, or 25 mg. Cortons of 3, 6, or 50.




## METANDREN

(methyl testosterone)

### LINGUETS FOR ABSORPTION VIA THE ORAL MUCOSA

Eoch Linguet contoins 5 mg. methyl testosterone. Supplied in boxes of 30 or 100 Linguets.

REFERENCES: 1. Goldman, S. F., and Markham, J. J.: Jl. Clin. Endocrin., 2: 237, 1942. – 2. McGavack, T. H.: Jl. Clin. Endocrin., 3: 71, 1943. – 3. Douglas, R. J.: Jl. of Urol., 45: 404, 1941. – 4. Heller, C. G., and Myers, G. B.: Jl. Clin. Inv., 21: 622, 1942. – 5. Werner, A. A.: Urol., 49: 872, 1943. – 6. Lisser, H., and Curtis, L. E.: Jl. Clin. Endocrin., 3: 389, 1943.

A RECENTLY PREPARED CIBA BOOKLET
ANDROGENIC THERAPY WITH PERANDREN AND METANDREN,
WILL BE SENT TO YOU ON REQUEST




*Steroid Hormones and Fine Pharmaceuticals*

CIBA PHARMACEUTICAL PRODUCTS, INC.
SUMMIT, NEW JERSEY
In Canada: Ciba Company Limited, Montreal

Perandren and Metandren—Trade Marks Reg. U. S. Pat. Off. and Canada



# Dependable Digitalization...

## *Rapidly if desired*

**VIRTUALLY FREE FROM LOCALLY CAUSED VOMITING**

THE patient with congestive heart failure requires prompt, dependable digitalization in order to bolster the failing myocardium to enable it to cope with the disturbed circulatory dynamics. Digitaline Nativelle offers advantages not found in whole digitalis leaf.[1]

Consisting of pure crystalline digitoxin, the chief cardiotonic glycoside of Digitalis purpurea, Digitaline Nativelle produces rapid dependable digitalization, within 6 to 10 hours if desired, *on oral administration.* Since it is quantitatively absorbed,[2] probably from the stomach, it produces virtually no nausea or vomiting from local irritation.

Because of its absolute uniformity of composition and dependable pharmacologic action, Digitaline Nativelle is administered by weight. One tablet of 0.1 mg. is the therapeutic equivalent of 1.5 gr. of standardized whole digitalis leaf. This quantity suffices in the average patient for dependable maintenance. Thus one tablet is given daily, and no different instructions to the patient are necessary.

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1. Gold, H.: The Choice of a Digitalis Preparation, Connecticut M.J. 9:1933 (Mar.) 1945.
2. Levine, S. A.: Clinical Heart Disease, 3rd ed., Philadelphia, Pa., W.B.Saunders Company, 1945, p.273.
3. Katz, L. N.; Wise, W., et al.: Oral Single-Dose Digitalization with Digitalis Leaf and Digitaline "Nativelle." Am.Heart J. 30:125 (Aug.) 1945.




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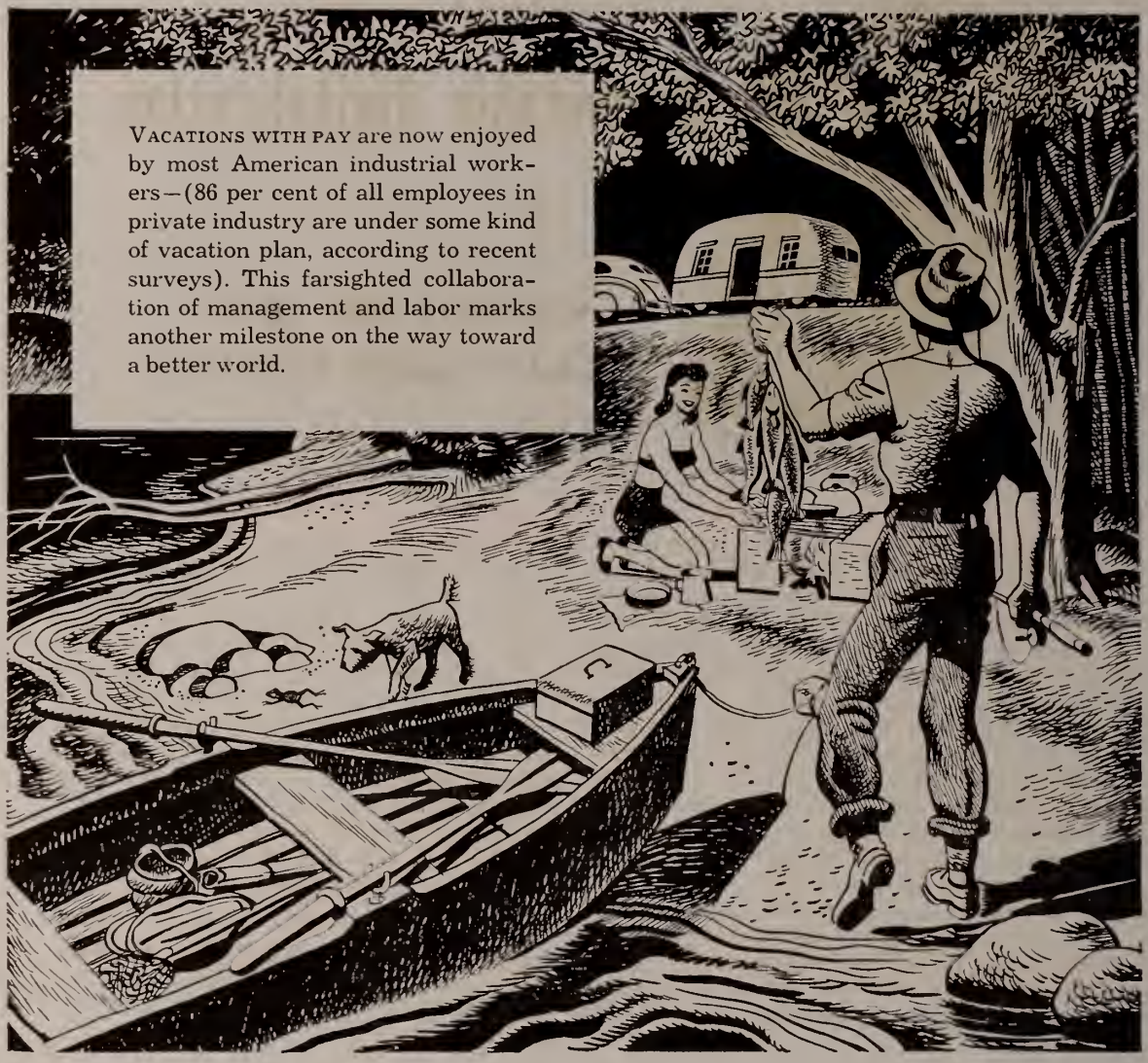
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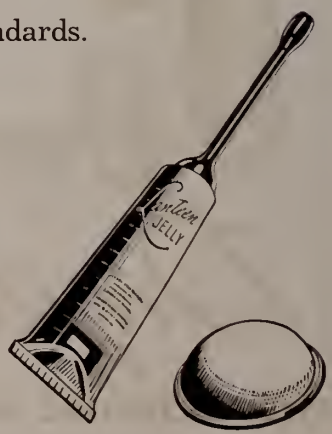
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*Swartz, J. H., and Blank, I. H.: J.A.M.A. 125:30 (May 6) 1944.

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TIRED AND WORN by the demands of the busy day, the average physician would much prefer home and family to an evening meeting of his medical society. He would like nothing better than a few hours of complete rest and relaxation. Medical progress, however, demands that he be ever alert. Or if he happens upon an experience which may be helpful to others, he willingly shares it. Advancement in medical practice must be common knowledge in order that people in general may benefit.

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The Illinois Medical Journal

August, 1946

VOL. 90, NO. 2

Official Journal of the Illinois State Medical Society

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# Editorials

## OLIN WEST, THE NEW PRESIDENT ELECT OF THE AMERICAN MEDICAL ASSOCIATION

At the recent meeting of the American Medical Association held at San Francisco July 1-5, Olin West of Chicago was elected to the office of President-elect of the American Medical Association by a unanimous vote. Doctor West who had been secretary and general manager of the A.M.A. for the past 24 years, resigned on April 1st of this year, and the Board of Trustees appointed George F. Lull as Secretary-General Manager until the meeting of the House of Delegates. Doctor Lull was likewise unanimously elected Secretary-General Manager by the House at the San Francisco meeting.

Doctor West has devoted the major portion of his professional life of nearly a half century to the interests of American medicine and members of the medical profession, keeping in mind at all times the best interests of the people as a whole. It was the privilege of the delegates from the Illinois State Medical Society to support heartily the candidacy of Doctor West for this position. The chairman of our delegation, Edwin S. Hamilton, made the nomination speech which received a second from nearly every other state delegation present. There was no other candidate presented.

Doctor West was brought before the delegates later that afternoon, and he received an unusual ovation, and made an excellent extemporaneous speech, quoting freely from his knowledge of present day medical problems in a most interesting manner. Since coming to Chicago in 1924 Doctor West has been enrolled as a member of the Illinois State Medical Society. His thousands of friends in this state, as well as elsewhere throughout the country, will be interested in his work and his appearances as a speaker during his year as President-Elect, and then the following year as President of the American Medical Association.

## ANTON J. CARLSON RECEIVED THE DISTINGUISHED SERVICE MEDAL

Each year at the first meeting of the House of Delegates at the annual A. M. A. session, one of the first orders of business is the selection of the outstanding man in Medicine to receive the Distinguished Service Award. Recommendations are received by the Board of Trustees which in turn, selects three candidates to be voted upon by the House of Delegates.

Anton J. Carlson of Chicago, one of the outstanding physiologists of this country, was one of the three selected, and won the nomination on the first ballot to be declared the 1946 recipient of the Distinguished Service Medal. Doctor Carlson has been very prominent for many years in his outstanding work in physiology, as well as standing as one of the most prominent biologists of the world. He has been president of the American Physiological Society, the Society for Ex-

perimental Biology and Medicine, the American Biological Society, and the American Association for the Advancement of Science.

Many Illinois physicians as well as thousands of others throughout the nation have had Doctor Carlson as a teacher. All will be happy to hear of this unusual recognition given to him, and all will be unanimous in approving the good judgment on the part of the delegates for extending him this honor. As the third Illinois physician to receive this award, Doctor Carlson stands high on the list of those who have been honored in the past few years.

## "BOOBY TRAP BILLS"

Under the above heading, an interesting editorial which appeared in the Los Angeles Examiner under date of July 8th, was received in the office of the editor. The editorial opens as follows: "There are three bills pending in Congress which had better be laid aside until the heat of summer — and of the left wing New Deal propaganda — subsides. One is the National Health Bill which would establish socialized medicine under federal domination. The second is a bill to create a National Science Foundation which would regiment all inquiry in the fields of physical sciences under a powerful bureaucracy.

"The third is the McMahon bill for the control of atomic energy which would destroy the fruitful incentive system of the United States Constitution, and the patent laws. Each of them is full of danger and deceit. They are separate but interlocking parts of a single pattern. None of them is being presented to Congress or to the people on its honest merits, if it has any . . . . . ."

To quote further, "Probably few persons would recognize the National Health Bill for what it is under the disguising title it now bears. It is not before Congress now in its original form. It was first presented as a section of the so-called 'General Welfare Bill' sponsored by Senators Wagner


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of New York and Murray of Montana, and Representative Dingell of Michigan. The PAC, the Communists and numerous other left-wing elements were its vehement supporters."

The article continues, "But the Wagner-Murray-Dingell bill, on inspection, proved to be such a monstrosity that even the New Deal lost hope of its enactment. Its socialized medicine section was therefore abstracted and sent to Congress as the 'National Health Bill' with an inaccurate presidential message blandly asserting that it is not a socialized medicine bill — an assertion which the text of the bill itself disproves.

"The National Health Bill, The National Science Foundation Bill and the McMahon Bill are all portions of the persistent attempt that is being made under unscrupulously false pretenses to sovietize the United States by means of misrepresented legislation in Congress."

In view of the fact that the medical profession has received much adverse criticism in recent months on account of their unalterable opposition to the Wagner-Murray-Dingell and other bills of a similar nature, it is most gratifying to see prominent newspapers carry editorials likewise condemning such activities. These criticisms have been increasing each month as the hearings before committee on the bills have progressed.

As the story of medical progress and its effects on the longevity of the American people, the decrease in both morbidity and mortality rates and other similar information, goes out so that the citizenry as a whole becomes thoroughly familiar with what the medical profession has done for health interests, it seems quite logical to believe that there will be a greater opposition to a change in the basic provisions of medical care as time goes on.

---

## ILLINOIS STUDY OF CHILD HEALTH SERVICE

The Study of Child Health Services which was inaugurated by the American Academy of Pediatrics at its meeting in St. Louis in November 1944 is developing into the most important and extensive project the Academy has undertaken.

The administration and conduct of the Study in Illinois is under the direction of the Academy State Chairman, Dr. Henry G. Poucher, a Study Committee and an Advisory Committee. Dr. George S. Frauenberger has been appointed Executive Director and the head office has been established in Evanston, Illinois, at 1465 Sherman Avenue. Progress of the Study can be found by reading Progress Pediatric Study.[1]

This project is unique in that it is a study by doctors of the situation in their own field of work, of the medical and dental care received by and available to children, of existing facilities for such care and the education of personnel giving the care.

It is not a survey by a lay group, a foundation or a department of the Government. It is in no way connected with the many plans proposed for medical care nor related to any of the federal proposals for medical care.

This Study is important. For unless the physicians undertake this task, others less qualified will, as indicated already by the action of the Federal legislators. Because its success will effect the future of children and the country, we ask and expect the cooperation of all physicians, dentists and agencies caring for children.

The Study is an opportunity for physicians not only to investigate their own affairs but also to collect factual data as a logical basis for sound medical care programs in their respective communities. The information obtained by the Study will be held confidential. Procedures of collecting data are so arranged that identities of individuals are lost. Statistical data will be available to authorized groups for future local community planning.

It is fully recognized that all doctors are exceptionally busy at this time. For that reason procedures for obtaining necessary information have been simplified as much as possible. The Survey offers the practicing physician an opportunity to determine the medical needs of his own community and to help him determine the best methods to meet these needs.

The importance of the survey can not be overemphasized. It is the first attempt of an organized group of medical men to inquire into its own affairs. It is a fact finding study undertaken by physicians to ascertain their strong and their weak points. Specifically the pediatrician will be asked to fill out a schedule dealing

---

[1]American Academy of Pediatrics, Study of Child Health Services. 7950 Rockville Pike (Bethesda Station), Washington 14, D. C.

with his own training and practice; to supervise the completion of a schedule for one or more hospitals in his community; to send out prepared letters to designated physicians informing them of the Study and requesting their cooperation in obtaining information on their practices as it affects children; and to assist the State Chairmen in discussing the program with local professional and non-professional groups. Physicians and dentists in general practice and specialists will be asked to complete a short one-paged schedule, mentioned above, concerning their pediatric practice.

This is the physician's opportunity to advance the standards of his profession. The opportunity is here, and the time is short. Will the physicians of Illinois demonstrate to the country as a whole that they are interested in the broader aspects of medical practice, or sit complacently by and be regulated by an outsider?

This program and this survey have been approved by the Council of the Illinois State Medical Society. The Advisory Committee has been designated as a permanent committee to cooperate with the Academy in completing this survey.

Members of the Committee from the Illinois State Medical Society are:

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Widespread response to the drawings, coupled with many requests for copies that might be framed, led to the issuance of this finely printed limited edition of the drawings, by Schering Corporation of Bloomfield, New Jersey, manufacturers of endocrine and pharmaceutical preparations for the medical profession. The full color reproductions in the portfolio are eleven by fifteen inches, mounted suitable for framing, and are devoid of any advertising. Portfolios are available free on request.

# Scientific Editorial

## TREATMENT OF GRAVES' DISEASE

J. H. Means, M.D.
BOSTON, MASS.

The profession these days has every right to be confused about how to treat patients with Graves' disease. At a recent meeting of the American Society for the Study of Goiter held in Chicago, one session was devoted largely to a discussion of the use of radioactive iodine in the treatment of this malady, another to its treatment by antithyroid drugs. The promoters of new therapies may state facts accurately, but misinterpret them. Their enthusiasm for their new forms of therapy may blind them to their possible limitations. This is not to say that such a situation of necessity prevails with respect to the treatment of Graves' disease. However, when confronted with any new therapy for which much is claimed, the profession must adopt a scientifically critical attitude with regard to it, until sufficient well controlled experience has been had to permit accurate and final evaluation.

The orthodox treatment of Graves' disease, namely, subtotal thyroidectomy in the properly prepared patient, gives results which, though not perfect, are nonetheless, in the main, highly satisfactory. Moreover, the use of antithyroid drugs combined with iodine, in the preparation of patients with thyrotoxicosis for thyroidectomy, bids fair to reduce operative mortality to the vanishing point. Under these circumstances, a non-surgical program must have proven superiority before it generally becomes adopted as standard therapy.

The introduction of antithyroid drugs provides one possible non-surgical way of treating Graves' disease. Good results have been obtained, but untoward side effects offset them to some degree. However, better drugs are constantly appearing, and it is possible that the perfect one will sometime be found, that is to say, one which cures the disease and has no untoward side effects. If this happens, thyroidectomy may become unnecessary, and the surgeon may find himself out of a job in the treatment of Graves' disease.

To the writer, the use of radio active iodine — which, after all, is nothing very different from the time honored x-ray treatment, except that it is applied from the inside instead of from the outside — seems to offer even more promise than that of antithyroid drugs. The difficulty, however, at present is that only a small number of patients have been treated with it, and although no mortality or untoward side effects have yet been observed, there is no way of telling that later on they may not make their appearance.

It is altogether desirable that the profession try these new therapies. They may be better than the old, but they should be tried with open eyes and due caution.

The writer suspects that the ultimate treatment of Graves' disease may not be any of those mentioned. All these methods are designed to suppress the function of the thyroid, but after all, the etiology of the disease is unkown, and the doctrine of the primacy of the thyroid may have to be abandoned as our knowledge of the pathogenesis widens. The ultimate treatment may level its attack at some point in the morbid mechanism proximal to the thyroid. The relation of the ophthalmic component of the disease to the thyrotoxic, is a complete mystery, and the problem of how to treat the eyes when they are heavily involved is really the greatest therapeutic problem now before us. Sometimes none of the forms of therapy aimed at the thyroid confer any benefit to the eyes — indeed the possibility exists that they may do harm. Much fundamental research must be done before we shall know how to deal with Graves' disease in its entirety.

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## LEADERS OF MEN

"All men are born equal." Never was there a more fallacious and more commonly accepted axiom.

Yeah — verily, "All men are born equal" in a democracy, and all men are born with eyes, ears, feet, hands, "inners," and even an inert mass called a brain. But my friends, *there* the equality stops! Every man is born with his own individualistic "germ cell" from which he springs, and this "germ cell" which later, when man matures, will come to be known as his "personality" — ah that "germ cell" makes men very *unequal* indeed. What is this "germ cell," whither does it come and when does it invade man?

I appreciate fully that I am treading on highly theoretical ground, but this is to be at most a quizzically speculative thesis.—This all important "germ cell," the precursor of "personality" is the combination of paternal and maternal heritage. It not only "invades" man, but it "institutes" man at conception, at the moment that the ovum and sperm conclude a successful contact. Roughly, nine months before another human being is tossed into the maelstrom of life, his "germ cell" comes into being and begins to develop and unfold its potentialities. And so my friends, all men not only are *born* but are *conceived* very *un*equally.

What varied potentialities are packed into this microscopic germ cell? Physical, metaphysical, mental qualities of an unborn animal? More, vastly more: longevity or the lack of it; ambition or sloth; kindliness or cruelty; propensities towards wealth or poverty; the urge towards Leadership or the moulding of Subserviance.

It is this one quality — Leadership — which I wish to discuss in detail and expound upon.

Leaders are born and not made. They are "created" and do not just happen. They owe their origin to their germ cell. I am chuckling as I write, anticipating the counter arguments and objections from both classes, from Leaders as well as those who are Led.

Let's look at it this way!

Great Leaders, both good and bad, be they Mayors of great cities, Governors of states, Senators, Presidents, Kings and Queens, Generals, Admirals, Clergymen, men and women in our Professions and the Industries — one and all, have one common denominator — a kindred germ cell. They did not and could not originate from sloth, laziness, sluggishness, but rather from an active, bubbling, mucoid, amoeboid moving germ cell! The first counter argument will be: Many Leaders had only a sluggish ancestry, both paternal and maternal. "Could be!" But if their number be too great to serve as exceptions to prove the rule, then we must look to a "skipped ancestry" of one or two generations.

Man just does not develop into a Leader from choice. It's too difficult, it's unnatural. He works and drives and develops, and arrives at Leadership because of an inner, unconscious, irrefutable urge — his primitive germ cell. He

often arrives at great heights in spite of himself. He tires physically and mentally, and yearns to become "mine-run" like you and like me, but can he? No! On he goes, haggard, worried, concerned, fretful, pitifully climbing to the heights which have been forced upon him.

You will counter with an objection and say: "But the offspring of Leaders in all walks of life are quite commonly failures, at least in the sense that they are utterly void of that very quality — Leadership — which their sires possessed. What happens to this germ cell?" My answer is logical, don't you think? Their sires burned it up, consumed it completely or at least vitiated it to the point of disappearance. Back we come again to our subject — "Leadership."

If Leaders are Leaders, in spite of themselves, they deserve no special praise, credit nor appreciation! Not only is that statement completely wrong, but in addition to meriting all three, they are entitled to still one more: pity! As a matter of fact, this desultory melange on Leadership and germ cells was inspired by the thought and hope that this thought could be created and proven to your satisfaction. Aye, verily, man becomes a Leader in spite of himself, driven on by the irresistible impulse engendered within his germ cell, but at what a cost, what a sacrifice to him! This restless disturbing upheaval within himself, this urging force which tears him out of the slowly moving placid herd and drives him madly on, and goads him to physical and mental efforts beyond the average endurance, and leaves him wan, fatigued and spent — is both a gift and a curse. It demands so much and gives so little! It demands not alone sacrifice of time and energy, but the forfeiture of the all too few commensurate gifts that come to the average man after his toil is done — calm, peace, relaxation. The Leader leads and rests not! We who are Led sit idly by and muse, wonder and criticize!

Man is born with an insatiable desire to avoid pain, misery, suffering, want, and to achieve perfect happiness. Accordingly, early in life he consciously or otherwise, selects for himself an ideal, a path towards happiness. These paths may be very divergent and include conquest, leadership or altruistic service to one's fellowman. Ultimately, however, they all converge upon a common objective — Happiness. And even though man realizes, through long and bitter experience that he will never completely attain his objective, on and on he goes in his mad pursuit of this elusive Will-O-the-Wisp.

Now, as I see it, you and I, of the "mine-run" variety, who belong to the vast army of those who are Led, have a distinct advantage over those who Lead. Our lives are more sheltered and we move at a slower tempo. Our path towards happiness is over the broad fields and through the cool and shady meadows which circle the mountains; no climbing of crags and no treacherous precipices to peril our journey. And when our day is done, and our sun is setting, and we wend our way peacefully homeward, we see our Leaders struggling and toiling up the steep mountainside — until as they finally reach the dizzy heights they seem to us diminutive animals of the hills, plodding along their difficult path, only to meet us again in the cool forests beyond the horizon.

Since our journey is the easier and our objective their objective, we owe them pity, appreciation and gratitude. Our hearts should be void of envy and our minds free from criticism. We should acclaim their restless energy, lighten their load, and appreciate the calm, dull stupid germ cell from which *we* sprang.

ANON.

# Medical Economics

The Medical Economics Committee — Chauncey C. Maher, Chmn., 6 North Michigan Avenue, Chicago, Edwin S. Hamilton, V. Thomas Austin, Emmet B. Bay, Jay McDonald Milligan, Jacob M. Mora, George Halperin, Marie Wessels, Thomas C. Browning, Roland R. Cross, Milton E. Bitter, Edwin F. Hirsch, Ford Hick, Lt. Col. MC, William J. Bryan, John R. Vonachen.

## CLINICS IN ILLINOIS

For a number of years a certain minority of physicians in this country have been engaged in clinic or group practice. By "clinic", we mean the privately owned association of physicians practicing medicine together, and do not refer to the special services of the larger charity hospitals, teaching institutions, etc. An outstanding example of this type of practice is the Mayo Clinic at Rochester, Minnesota, and the remarkable success of this institution has undoubtedly provided the stimulus for the formation of many of the smaller and less well known organizations. Further definition of the term "clinic" is exceedingly difficult. At present time, any individual, physician or not, ethical or otherwise, practicing alone or with a single associate is at liberty to refer to his offices as a "clinic", and as a matter of fact, such a practice is not uncommon. Because of this confusion in terminology, registration of clinics has never been practical.

The current outside pressure against the medical profession to enforce a change, prompts us to take stock of our present facilities. The public has been informed that it needs, among other things, reasonably accessible diagnostic units, built around a well equipped hospital staffed with specialists. Certainly this public service could be provided by any general hospital with its staff of private practitioners, but just as surely such a service would be available in any clinic worthy of the name. Numerous surveys of hospitals have been conducted and various boards have been set up to improve hospital standards. But what of clinics? To what extent do they supplement the general hospitals in providing special diagnostic facilities, consultations and improved methods of treatment? To what extent do they measure up to a standard? This information is not available in Illinois, and it is unlikely that it is available elsewhere.

Obviously, the first step in any analysis of our clinic facilities is a non-critical census. Accordingly, in October, 1945, questionnaires were addressed to each of the secretaries of the 92 county medical societies in the state of Illinois. They were asked to provide us with the names of all clinic groups in their county, regardless of size. They were further asked to give the approximate membership in each group, and to indicate whether or not the members thereof were members of their respective county medical societies. Only ethical organizations were to be included in the survey. Six weeks later, follow-up letters were sent to those not responding to the original questionnaire. The over-all response was good, and information was received from every county except Cass, Coles-Cumberland, Crawford, Henderson, Johnson, Montgomery, and St. Clair.

As was to be expected, definite information was not immediately available from Cook County. Dr. Warren Furey, Secretary of the Chicago Medical Society, kindly suggested the publication of a questionnaire, to elicit such information, in the Chicago Medical Society Bulletin. However, because of the difficulties involved in conducting a survey of such a large metropolitan area, it was decided to omit Cook County from the initial census, and attempt to include it in a later survey to be considered when the various groups are back on a peace time basis. The membership of most clinics was markedly decreased during the war.

and as a matter of fact, enlistment in the armed services resulted in the discontinuance of some. This fact should be kept in mind when considering the size and number of the clinics listed below.

Correct interpretation of some returns was difficult. In several instances, the names of two or more doctors were given indicating that they practiced together. Apparently no clinic name was used and they were therefore not included in this roster.

Finally, it should be emphasized that this roster of clinics was compiled without information directly from the clinics concerned, that the secretaries of the county medical societies were asked to give the approximate size of the groups, and that the demobilization of physicians between the time of this survey and its publication will have resulted in a considerable increase in the size of many.

| NAME | LOCATION | NO. OF PHYSICIANS |
|---|---|---|
| Carle Hospital Clinic | Urbana | 17 |
| Christie Clinic | Champaign | 15 |
| Quincy Clinic | Quincy | 8 |
| Patton Clinic | Springfield | 7 |
| Sloan Clinic | Bloomington | 7 |
| Paris Clinic | Paris | 6 |
| Canfield Clinic | Rockford | 6 |
| Besley Waukegan Clinic | Waukegan | 5 |
| Coleman Clinic | Canton | 5 |
| Macomb Clinic | Macomb | 5 |
| Effingham Clinic | Effingham | 5 |
| Dreyer-Denney Clinic | Aurora | 5 |
| Olney Sanitarium Clinic | Olney | 4 |
| Springfield Clinic | Springfield | 4 |
| Deal Clinic | Springfield | 4 |
| Mattoon Clinic | Mattoon | 4 |
| Mattoon Polyclinic | Mattoon | 4 |
| Standard Clinic | Macomb | 3 |
| Collins-Bellas Clinic | Peoria | 3 |
| Hanna Clinic | Peoria | 3 |
| Kankakee Clinic | Kankakee | 3 |
| Holland Clinic | Macomb | 2 |
| Ferrell Hospital Clinic | Eldorado | 2 |
| Bucher Clinic | Champaign | 2 |
| Murphy Clinic | Dixon | 2 |
| Gailey Eye Clinic | Bloomington | 2 |
| Stanman Clinic | LaSalle | 2 |
| Greer Brothers Clinic | Vandalia | 2 |
| Seigert Clinic | Pana | 2 |
| Rockford Clinic | Rockford | 2 |
| Burrough-Stanelle Medical Center | New Haven | 2 |

On the basis of these findings, it would seem that there are approximately 31 clinics in the state, exclusive of Cook County and the few counties not recorded. Of these clinics, 21 have a membership of 3 or more. The total number of physicians engaged in clinic practice is 141.

In addition to these clinic listings, there were reported 16 associations of two doctors practicing together, and one group of four.

In an effort to determine whether the number of clinics was increasing or decreasing, each secretary was also asked to list all clinics which had become inactive in his county. There were six, and of this number at least two had become inactive because of enlistment of its members in the armed services. V.T.A.

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## MEN PREDISPOSED TO HEART DISEASE BY THICKNESS OF ARTERY LINING

Medical science established some time ago the fact that coronary disease is far more frequent in men then in women and now a Brooklyn doctor tells why—the inner lining of the heart arteries is about three times thicker at birth in the male than in the female.

Writing in the July 13 issue of *The Journal of the American Medical Association,* William Dock, M.D., from the Department of Pathology, Cornell Medical College, and the Department of Medicine, Long Island College of Medicine, states that after performing postmortem examinations on 12 infants of each sex dead within 24 hours of birth, he found that the thickness of the inner lining of the arteries averaged 26 per cent in newborn males and eight per cent in females.

The presence of high blood pressure is one of the conditions that may predispose men born with thickened artery linings to have heart disease. The passage in the arteries of such men is narrower than that of women; therefore, a clot may form in one of the heart arteries or one of the branches and deprive the heart muscle of blood for a length of time sufficient to do damage.

Atherosclerosis, which causes a degeneration of the inside lining of the arteries, is one of the diseases said by the author to have a predilection for the coronary arteries. This the author ascribes to the thickness of these vessels.

"While the anatomy of the coronaries plays a decisive part in preparing the ground for atherosclerosis and accounts for the difference in the incidence of myocardial infarction in the sexes, it would be most unfortunate," the author states, "if physicians regarded coronary occlusion as an inevitable fate for those with the inborn characteristic. On the contrary, as hypertension and cholesterol metabolism become better understood and controllable there is every reason to believe that there will be a decline from the present appalling death rate from coronary disease to the insignificant level now prevailing in other populations, such as the Chinese. Here lies the greatest opportunity for medical science to prolong the effective years of life."

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"Why is it," asked the irritable customer, "I never get what I ask for here?"

"Perhaps, madam," said the assistant, smiling coldly, "we are too polite."

# Correspondence

## NEW OFFICERS FOR UROLOGICAL SOCIETY

At the Annual Meeting of the Chicago Urological Society held May 23, 1946, the following offers were elected: President, Dr. L. W. Riba; Vice-President, Dr. Irving J. Shapiro; Secretary-Treasurer, Dr. James W. Merricks.

## SURGICAL ASSEMBLY TO BE HELD IN DETROIT

An international surgical assembly sponsored by the United States Chapter, International College of Surgeons will be held in Detroit October 21-22-23, 1946. An intensive clinical and didactic program by world authorities will be presented.

All medical men and women in good standing are cordially invited. Program and information on the Assembly and the primary qualifications for Fellowship in I. C. of S. are available by writing L. J. Gariepy, M.D., Secretary, 16401 Grand River, Detroit 27, Michigan.

## NEW ORGANIZATION TO ENCOURAGE RESEARCH, COMBAT ANTIVIVISECTIONISTS

The National Society for Medical Research, a clearing house for information on medical studies and discoveries, has been organized under the sponsorship of the Association of American Medical Colleges with the cooperation of 101 national scientific organizations.

Dr. Anton J. Carlson, President of the National Society for Medical Research and Professor Emeritus of Physiology at the University of Chicago, has announced the establishment of the Society's headquarters office in Chicago, Illinois. Ralph A. Rohweder, 1946 President of the Chicago Junior Association of Commerce and former consultant and editor for the National Safety Council, has been appointed Executive Secretary.

The Society has as its purpose the advancement of research in medicine, biology, pharmacy, dentistry, and veterinary medicine.

Dr. Carlson emphasized that an important function of the Society is to analyze and expose the propaganda of small but highly vocal groups which object to the use of animals in the experiments without which medical science would still be in its infancy.

Every year doctors and researchers must take time from their vital duties to defeat legislation proposed by these groups which would hamper or stop the work of the medical profession.

Secretary-Treasurer of the National Society for Medical Research is Dr. A. C. Ivy, of the University of Illinois. On the Board of Directors are Alfred Blalock, Johns Hopkins University; C. S. Burwell, Harvard University; E. J. Carey, Marquette University; L. R. Chandler, Stanford University; W. C. Davison, Duke University; R. E. Dyer, National Institute of Health; H. S. Gasser, Rockefeller Institute; E. W. Goodpasture, Vanderbilt University; J. G. Hardenbergh, American Veterinary Medical Association; J. C. Hinsey, Cornell University.

Victor Johnson, American Medical Association; C. D. Leake, University of Texas; E. M.

MacEwen, University of Iowa; W. S. McEllroy, University of Pittsburgh; B. O. Raulston, University of Southern California; A. M. Schwitalla, St. Louis University; Isaac Starr, University of Pennsylvania; E. L. Turner, University of Washington; Floyd S. Winslow, Medical Society, State of New York.

National offices of the Society are at 25 East Washington Street, Chicago, Illinois

## MISSISSIPPI VALLEY MEDICAL SOCIETY MEETING AT ST. LOUIS SEPTEMBER 25-26-27

The 11th Annual Meeting, Mississippi Valley Medical Society, will be held at the Hotel Jefferson, St. Louis, September 25-26-27. Clinical teachers from the leading medical schools will conduct this post-graduate assembly planned to appeal to general practitioners. There will be technical and scientific exhibits, noon-day round table luncheons, and a banquet, preceded by a social hour. Dr. Arthur H. Compton, Nobel Prize Laureate and Chancellor of Washington University will be the principal banquet speaker, together with the Presidents of the Illinois, Iowa and Missouri State Medical Societies. All ethical physicians are cordially invited to attend. A detailed program may be obtained from the Secretary, Harold Swanberg, M.D., 209-224 W.C.U. Bldg., Quincy, Ill.

## TRANSFER OF INDIVIDUAL STEERING AND ADVISORY SERVICE

After July 1, 1946, all inquiries regarding individual problems and the use of psychiatric facilities and resources in such cases will be handled in the offices of the Community Referral Service.

The Illinois Society for Mental Hygiene will continue to serve as a clearing house on subjects relating to mental hygiene and to comply with requests for specialized information to individuals and groups with particular interests or responsibilities in this field.

## GARDINER GENERAL HOSPITAL WILL BE FIFTH ARMY HEADQUARTERS

In response to requests for the conversion of the Gardiner General Hospital, Chicago, Illinois, for non-military use Secretary of War Robert P. Patterson announced that it was necessary for the War Department to retain the property as Headquarters for the Fifth Army and Fifth Army Area.

In making the announcement, the Secretary said a thorough survey of other available sites for the Army Headquarters had shown the federally-owned property now occupied by Gardiner Hospital as the most suitable. He added that he had reluctantly turned down a request of the Federal Public Housing Authority to convert the hospital into a housing unit.

## OFFICE PAINS

The following original poem by Audrey E. Oaks, Secretary to Frank R. Hall, M.D., of Batavia, N. Y., describes the impressions of the physician's office secretary so well, we are sharing it with you.

Milling patients by the score,
Pass in through our office door.

Patients sixty, patients four,
Quiet ones and those who roar.

Itch or pain or scratch or sore,
Fingers crushed between a door.

Some drop ashes on the floor,
That's what burns me to the core.

There's the one I'd gladly choke,
There's the one who's always broke.

Some are short and some are tall,
Some are fat and some are small.

There are those who can't sit still,
Others never pay their bill.

There are those who sit and stare,
There are also ones that glare.

Some are always in a rush,
There are some that always gush.

However, it's not hard to pick,
The patient who is really sick.

Doctor's office is a riot,
Honest, folks, you ought to try it.

# House of Delegates

SECOND SESSION

The second session of the House of Delegates was called to order by the President, Dr. E. P. Coleman, on Thursday, May 16, 1946, at 9:40 A.M.

THE PRESIDENT: The first order of business is the report of the Credentials Committee.

DR. E. S. HAMILTON: The Credentials Committee has certified 52 delegates from the Chicago Medical Society, 61 from downstate, and 13 officers and members of the Council, making a total of 126. I move you, Mr. President, that this number be designated the official voting body for this meeting. (Motion seconded by Dr. W. S. Bougher, Chicago, and carried).

THE PRESIDENT: The next order of business is the roll call by the Secretary.

THE SECRETARY: We have the attendance slips which correspond to the report Dr. Hamilton read.

DR. HAMILTON: I move that the attendance slips be accepted as the official roll call. (Motion seconded by Dr. F. O. Fredrickson, Chicago, and carried).

THE PRESIDENT: The next order of business is the reading and approval of the minutes of the first meeting of the House.

(The Secretary read the minutes and as there were no corrections, they were accepted).

THE SECRETARY: This morning I received the following telegram from Dr. C. E. Wilkinson:

"Your telegram of greetings and best wishes from the House of Delegates received and greatly appreciated. Sorry not to be with you. I always look forward to this annual meeting of the Illinois State Medical Society. Kindly give my best wishes to all the officers and members. I am sure you are having a very successful meeting."

THE PRESIDENT: The next order of business is the election of officers. Nominations for president-elect are called for.

DR. L. O. FRECH, Decatur: I want to present the name of the Dr. I. H. Neece for president-elect. (Seconded by Dr. J. S. Templeton, Pinckneyville).

DR. L. J. HUGHES, Elgin: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Neece. (Motion seconded by L. O. Frech, and carried).

(The ballot was cast and the President declared Dr. I. H. Neece, Decatur, elected as president-elect).

THE PRESIDENT: Nominations are in order for first vice-president.

DR. P. E. HOPKINS, Chicago: I wish to nominate Dr. Chauncey C. Maher for first vice-president. (Motion seconded by Dr. F. O. Fredrickson, Chicago).

DR. J. J. MOORE, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Maher. (Motion seconded by Dr. Hopkins and carried).

(The ballot was cast and the President declared Dr. Chauncey C. Maher, Chicago, elected as first vice-president).

THE PRESIDENT: Nominations are in order for second vice-president.

DR. W. O. THOMPSON, Chicago: I wish to nominate Dr. John P. O'Neil as second vice-president. (Motion seconded by Dr. E. H. Ochsner, Chicago).

DR. J. J. MOORE, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. O'Neil. (Motion seconded by Dr. Thompson and carried).

(The ballot was cast and the President declared Dr. J. P. O'Neil, Chicago, elected as second vice-president).

THE PRESIDENT: Nominations are in order for secretary-treasurer.

DR. E. E. DAVIS, Avon: I wish to place in nomination the name of Dr. Harold M. Camp to succeed himself. (Motion seconded by many).

DR. I. H. NEECE, Decatur: I move that the nominations be closed and the President instructed to cast the affirmative ballot for Dr. Camp. (Motion seconded by Dr. L. O. Frech, Decatur).

(The ballot was cast and the President declared Dr. H. M. Camp elected as secretary-treasurer).

THE PRESIDENT: The next order of business is election of Councilors for the 1945 term, for two years, the terms of Oscar Hawkinson, Third District, Walter Stevenson, Sixth District, Andy Hall, Ninth District,

and G. C. Otrich, Tenth District, expiring, and for the 1946 term, to be elected for three years, E. W. Mueller, Third District, Charles P. Blair, Fourth District, Ralph P. Peairs, Fifth District, I. H. Neece, Seventh District, and C. E. Wilkinson, Eighth District, retiring.

The Chicago Medical Socicty has two retiring members to be elected, and if certain changes are made in the by-laws they will be entitled to three additional councilors. This amendment to the by-laws has not taken effect, therefore, in this election only two councilors from the Chicago Medical Society will be elected. If the amendment is approved later in the morning, then the other three councilors will be elected.

DR. LUCIUS COLE, Oak Park: I wish to nominate Dr. Oscar Hawkinson as Councilor for the Third District to succeed himself.

DR. R. K. PACKARD, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Hawkinson. (Motion seconded by Dr. W. O. Thompson, Chicago, and carried).

(The ballot was cast and the President declared Dr. Oscar Hawkinson, Oak Park, elected as Councilor from the Third District for two ycars).

DR. A. H. BITTER, Quincy: I wish to nominate Dr. Walter D. Stevenson, Quincy, as Councilor of the Sixth District to succeed himself. (Seconded by Dr. E. E. Davis, Avon).

DR. BITTER: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Stevenson. (Motion seconded by Dr. F. M. Hagens, Lincoln, and carried).

(The ballot was cast and the President declared Dr. Walter D. Stevenson, Quincy, elected as Councilor of the Sixth District for a term of two years).

DR. ANDY HALL, Mt. Vernon: I wish to nominate Dr. C. O. Lane, West Frankfort, as Councilor of the Ninth District. (Motion seconded by Dr. I. H. Neece, Decatur).

DR. LEE O. FRECH, Decatur: I move that the nominations be closed and the Secretary cast the affirmative ballot for Dr. Lane. (Motion seconded by Dr. A. H. Bitter, Quincy, and carried).

(The ballot was cast and the President declared Dr. C. O. Lane, West Frankfort, elected as Councilor of the Ninth District for a term of two years).

DR. MATHER PFEIFFENBERGER, Alton: I wish to nominate Dr. G. C. Otrich, Belleville, as Councilor of the Tenth District. (Motion seconded by Dr. C. O. Lane, West Frankfort, and carried).

DR. V. A. McCLANAHAN, Aledo: I move that the nominations be closed and the Secretary instructed to cast the affirmativc ballot for Dr. Otrich. (Motion seconded by Dr. Pfeiffenberger and carried).

The ballot was cast and the President declared Dr. G. C. Otrich, Belleville, elected as Councilor of the Tenth District for a term of two years).

DR. E. W. MUELLER, Chicago: I would like to nominate Dr. Harry M. Hedge as Councilor of the Third District for a term of three years. (Motion seconded by Dr. Oscar Hawkinson, Chicago).

DR. HAROLD W. MILLER: I move that the nominations be closed and the Secretary cast the affirmative ballot for Dr. Hedge. (Motion seconded by Dr. V. A. McClanahan, Aledo, and carried).

(The ballot was cast and the President declared Dr. Harry M. Hedge elected as Councilor of the Third District for a term of three years).

DR. E. E. DAVIS, Avon: I wish to nominate Dr. Charles P. Blair, Monmouth, as Councilor of the Fourth District to succeed himself. (Motion seconded by Dr. L. J. Hughes, Elgin).

DR. V. A. McCLANAHAN, Aledo: I move that the nominations be closed and the Secretary cast the affirmative ballot for Dr. Blair. (Motion seconded by Dr. E. E. Davis, Avon, and carried).

(The ballot was cast and the President declared Dr. Charles P. Blair, Monmouth, elected as Councilor of the Fourth District for a term of three years).

DR. FRANK M. HAGENS, Lincoln: I wish to nominate Dr. Ralph P. Peairs as Councilor of the Fifth District to succeed himself. (Motion seconded by Dr. Frank Deneen, Bloomington).

DR. E. E. DAVIS, Avon: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Peairs. (Motion sec onded by Dr. Frank Hagens, Lincoln, and carried).

The ballot was cast and the President declared Dr. Ralph P. Peairs, Normal, elected as Councilor of the Fifth District for a term of three years).

DR. I. H. NEECE, Decatur: I would like to place in nomination the name of Dr. Charles H. Hulick, Shelbyville, as Councilor of the Seventh District for a three year term. (Motion seconded by Dr. L. O. Frech, Decatur).

DR. W. C. WILHELMJ, East St. Louis: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Hulick. (Motion seconded by Dr. Neece and carried).

(The ballot was cast and the President declared Dr. Charles H. Hulick, Shelbyville, elected as Councilor of the Seventh District for a three year term).

DR. G. R. INGRAM, Champaign: I would like to nominate Dr. Harlan English, Danville, as Councilor of the Eighth District to succeed Dr. Charles E. Wilkinson. (Motion seconded by Dr. I. H. Neece, Decatur).

DR. V. A. McCLANAHAN, Aledo: I move that the nominations be closed and the Secretary instructed to cast the affirmativc ballot for Dr. English. (Motion seconded by Dr. Ingram and carried).

(The ballot was cast and the President declared Dr. Harlan English, Danville, elected as Councilor of the Eighth District for a three year term).

THE PRESIDENT: The next order of business is the election of delegates to the American Medical Association. There are five to be elected from Cook County, three for two years and two for one year, Drs. Rollo K. Packard, Charles H. Phifer, J. J. Pflock, G. Henry Mundt and R. H. Hayes retiring.

There are four to be elected from downstate, two for two years, two for one year, Drs. E. S. Hamilton, Lee O. Frech, C. E. Wilkinson and Mather Pfeiffenberger retiring.

(The following delegates were nominated, the ballot was cast and the President declared them elected: From Cook County for two years, Drs. Rollo K. Packard, G. Henry Mundt and Charles H. Phifer, for one year, Drs. Robert H. Hayes and Fred Muller. From downstate for two years, Drs. E. S. Hamilton and W. I. Lewis; for one year, Drs. Mather Pfeiffenberger and George C. McGinnis).

THE PRESIDENT: The next order of business is the election of Alternate Delegates to the American Medical Association. There are five to be elected from Cook County, three for two years and two for one year, Drs. H. K. Scatliff, Frank L. Brown, D. B. Pond, Gustav Kaufman, and Fred H. Muller, retiring. There are four to be elected from downstate, two for two years and two for one year, Drs. Bernard Klein, K. B. Rieger, C. O. Lane, and E. C. Kelly, retiring.

(The following alternate delegates were nominated, the ballot was cast and the President declared them elected: From Cook County for a term of two years, Drs. Frank L. Brown, Gustav Kaufman, and Darwin B. Pond; for one year, Drs. Warren Furey and H. K. Scatliff. From downstate for a term of two years, Drs. Bernard Klein and K. B. Rieger; for one year, Drs. D. M. Roberts and W. W. Fullerton).

THE PRESIDENT: The next order of business is the election of Standing Committes.

(The following members of Committees were nominated in turn, the ballot cast and the President declared them elected:

*Committee on Profession Demeanor*: Oscar Hawkinson, 1948; A. L. Nickerson, 1948; Frank Bihss, 1949; P. R. Blodgett, 1949.

*Committee on Medical Education and Hospitals*: W. O. Thompson, for two years, 1948; H. O. Munson, for three years, 1949.

*Committee on Medical Benevolence*: Lucius Cole, for two years, 1948; Harold M. Camp, for three years, 1949.

*Committee on Archives*: Ellsworth Black, E. P. Weld.

THE PRESIDENT: The next order of business is fixing the per capita assessment for 1947 dues.

*REPORT OF COMMITTEE ON MISCELLANEOUS BUSINESS AS REFERRED BY THE PRESIDENT*

Your Committee recommends the adoption of the resolution offered to raise the dues of the members of the Illinois State Medical Society to $10.00 a year.

Respectfully submitted,
C. PAUL WHITE, Chairman
L. O. FRECH
EUGENE McENERY

DR. WHITE: I move the adoption of this report. (Motion seconded by Dr. F. O. Fredrickson, Chicago, and carried.)

The next order of business is the selection of a meeting place for the 1947 annual meeting.

DR. G. HENRY MUNDT, Chicago: I move that it be left to the discretion of the Council. (Motion seconded by Dr. V. A. McClanahan, Aledo, and carried).

THE PRESIDENT: The next order of business is the reports of Reference Committees and action on same. The first report will be from the Committee on Reports of Officers.

DR. ROBERT H. HAYES, Chicago: Your Reference Committee on Reports of the President, President-elect, Secretary-Treasurer and Chairman of the Council makes the following report:

Many problems have arisen since the last session of the House of Delegates mostly due to post-war conditions and changing public opinions pertaining to sociological and economical conditions. Many of these problems are ably set forth in the reports of the officers above designated. Due to much repetition in the reports we have attempted to coordinate our findings and thus omit much of the repetition.

The President's report and the President-elect's report will be considered together.

Your committee commends the report of Dr. Coleman, and is in sympathy with a prepayment insurance plan. We wish he had defined more clearly service-connected disabilities.

In the light of present demands of increased payment by the group seeking compulsory health insurance, why should we the doctors agree to a set low minimum fee?

We should support the movement that the returning veteran should be cared for by the physician of his choice. It is not clear whether or not the physician or a governmental agency decides who is to pay for such service and whether it comes within the category of service connected disability or not. Returning war doctors to Chicago have had difficulty in finding office space, but with the aid of the Chicago Medical Society in contacting managers of large buildings in the loop, as well as outlying sections, this problem is now pretty well solved. More hospitals in Chicago are making application at the present time for residencies to take care of the returning doctor to better equip himself, to render better medical care to his patients.

We should have a publicity program for the doctor, to enlighten him upon the solution of complex problems now facing the medical profession, impress upon each doctor the self sacrifice necessary to make this a bigger and better society, it is his job and not that of the officers.

What hearings did the Secretary attend in Washington? Was it relative to War Department assignments, or allocation of physicians to communities without doctors?

Special attention should be made to the splendid cooperation we are getting from the State Health Department through Dr. Roland Cross. He is attempting to enforce the patient-doctor relationship for which we are continually striving.

Miss McArthur is doing a fine job, but we believe that her work could be widened by including the educational program to the doctor, as well as to the public. This perhaps could be taken care of through the Committee on Medical Service and Public Relations.

More publicity should be given to the relative cost of compulsory health insurance as against a private prepayment plan.

The necessity for keeping the good will of the farmer organizations cannot be too strongly emphasized. This can well be done by a little more publicity to the doctor in farming communities, especially along the lines of how will a compulsory health insurance program provide more doctors to rural communities.

Endorsement of a prepayment plan — In so doing we should always consider physician or doctor-patient relationship, which an indemnity plan does not strictly provide, for here the insurance company pays the patient, who in turn pays the doctor. The danger here is that the insurance company may imply that they could find for the patient a doctor who would do the work for the sum allowed under the insurance company's fee schedule. When this occurs we no longer have the simple physician-patient relationship, but entrance of a third party, the insurance company (through the patient).

Illinois has been slow in adopting a prepayment plan because of lack of enabling legislation. This has only recently been obtained, and since then the state society has recommended a voluntary prepayment plan, by permission of the State Insurance Department.

We should emphasize the fact that the Wagner-Murray-Dingell bill is more of a menace to the public than it is to the doctor.

We feel that Dr. Coleman was far too mild in his report in reference to increasing the dues, for if we ever were faced with a crisis requiring the expenditure of large sums of money, we are so at the present time; therefore, we suggest strong support for an increase in the yearly dues, in line with those of surrounding states.

We should publicly emphasize the fact that we are not opposed to giving the people adequate medical care according to their ability to pay, and if their communities are unable to provide facilities sufficient to attract medical men to their respective communities, then some form of subsidy either private or governmental must be promoted in order to provide them with adequate medical care.

We want to emphasize that it should be the duty of any President-elect to attend all executive committee meetings, as well as all other committee meetings of the state society that are humanly possibly for him to attend.

The keynote to both Dr. Coleman and Dr. Berghoff should be — Go Ahead with Cooperation and Self-sacrifice.

We favor going on record as opposed to bureaucratic control and in favor of individual free enterprise.

(DR. HAYES: I move the adoption of this portion of the report. Motion seconded by Dr. L. O. Frech and carried).

*Report of the Secretary-treasurer*: Your Committee is well satisfied with the report of Dr. Harold M. Camp, and wish to compliment him and the Society for the excellent work he is doing for the profession of Illinois.

We feel proud of Illinois' contribution to the medical armed forces of our government, of its approximate 4500 physicians, most of whom gave up a lucrative practice to serve, some of whom made the supreme sacrifice. We owe these men a debt of gratitude. Now that most of them have returned to resume practice or take refresher courses, we should see to it that they speedily resume their place in society.

We are proud of the service the Illinois Procurement and Assignment Service rendered to our government and feel reluctant to have their service discontinued after May 15. They have done a masterful job since the ending of hostilities by the separating of physicians from service and have acted in an advisory capacity in advising and reassigning physicians to communities to meet the needs of inadequate medical situations.

We agree with Dr. Camp that the postgraduate meetings should be continued and broadened. They have proved of imminent benefit to the physicians of the state and material benefit to the health of the public.

While another reference committee will report on the "Committee on Medical Service and Public Relations" we are convinced that too much praise cannot be given this committee for their report after prolonged, frequent and arduous endeavor in setting up a workable plan for pre-paid medical insurance. No plan can meet with the wholehearted endorsement of everyone concerned, yet this plan is considered workable by the majority and is a step forward to meet the changing economic and social trends demanded by the public.

More praise is due to Governor Green for vetoing a vicious bill, "House Bill 250", which would have required every physician to give first aid in any emergency. This is one more example of the high confidence Governor Green has in the integrity of the Illinois medical profession.

We commend the Council of the State Medical Society for procuring, after long deliberation, a Public Relations Counsel. We hope he may be better able to coordinate the work and aims of the profession with the public demands, thus preventing and counteracting unfavorable criticism and exploiting of the medical profession.

Your committee wishes to pay high tribute to Dr. Roland Cross, Director of Public Health in Illinois, for his loyalty and cooperation with the Illinois State Medical Society. His untiring efforts to coordinate all public health programs with the profession have been of great benefit to public health. By appointment of the governor several advisory commissions have

been appointed of medical men interested in the different specialties, who have conferred with Dr. Cross in health matters which have proved of immense value in establishing standards for administering health measures beneficial to the public.

(DR. HAYES: I should have given Robert S. Berghoff credit for the appointment of these advisory committees because he is chairman of the Governor's committee on Public Health).

The reference by Dr. Camp in regard to increasing the dues of the Society meets with the approval of the committee. Illinois for a major state and being one of the world's largest medical centers, has the smallest dues of any state of like population and wealth. Your committee feels that dues should be collected from returning servicemen within ninety days after discharge from service.

The Veterans' Administration has evidenced its willingness to cooperate with the Illinois State Medical Society in adopting a fee schedule submitted by the State Society. We should feel elated that at least one Federal Government Administration has given its endorsement and that the veteran shall have free choice of physician and hospital, thus retaining the personal relation of patient and physician.

Your committee wishes to state its opposition to the Wagner-Murray-Dingell Bill, Senate Bill 1606, because of its many controversial and false statements, the dogmatic attitude of its proponents and unfair attitude toward its opponents. These tactics show all too plainly the feeling its sponsors have toward the American way of medical practice.

Let every individual physician in Illinois send a personal protest against Senate Bill 1606 to Senators Murray, Lucas and Brooks, opposing this vicious undemocratic bill, which will take away from the profession and the public the right of free choice, health and happiness.

Your committee is pleased to note the excellent financial condition of the Illinois State Medical Society and congratulates its financial advisers.

(DR. HAYES: I move the adoption of this section of the report. Motion seconded by Dr. F. O. Fredrickson, Chicago, and carried).

*Report of Chairman of the Council*: The committee wishes to express appreciation and gratitude for time, effort and capable service rendered by the chairman of the Council. We feel that his sacrifice of time and effort has been enormous and his leadership commendable toward the most desirable solution of organized medicine's troublesome problems.

We note with joy that the Journal Committee's acting with the Editor, the Editorial Board and the Business Manager of the Journal have made such progressive and substantial improvement in the Journal. Considering the conditions under which they have worked, the results are really worthy of special commendation.

We note with special interest the four postgraduate meetings held during the past year, and the plan to increase the number to ten this next year. With this effort we most heartily agree, and hope that through these meetings the cause and value of organized medicine can be better sold to the general practitioner in rural communities. It is through these general practitioners that the special committee of which Dr. Harlan English of Danville is chairman can get better cooperation with the farm groups. We would humbly suggest that the Council bring more pressure on the general medical man that he write or wire his congressman and senator regarding medical legislation.

(DR. HAYES: I move the adoption of this portion of the report. Motion seconded by Dr. J. J. Moore, Chicago, and carried).

Respectfully submitted,
(Signed) ROBERT H. HAYES, Chairman
RICHARD GREENING
ERNEST E. DAVIS

DR. HAYES: I move the adoption of the report as a whole. (Motion seconded by Dr. R. K. Packard, Chicago, and carried).

THE PRESIDENT: We will hear the report of the Committee on Reports of Individual Councilors, which will be presented by Dr. A. H. Bitter.

DR. BITTER: The Committee on Reports of Councilors wishes to report four outstanding facts which occur in the summation of the Councilor reports:

(1) The widespread approval of the Prepayment Medical Insurance Plan by the doctors throughout the state.

(2) The return of medical men who were in military service and their rapid readjustment to civilian practice.

(3) The state-wide effort of our state government to accept advice and cooperate with the medical profession in the control of tuberculosis and the care of the chronically ill.

(4) The sinister efforts of the federal government to force socialized medicine upon the public is gradually losing support due to the efforts of the medical profession throughout the United States, who have been awakened from their passive lethargic defeatist attitude and have struck back with forceful propaganda and constructive measures which follow the American pattern and rules of free enterprise.

(Signed) A. H. BITTER, Chairman
H. K. SCATLIFF

DR. BITTER: I move the adoption of this report. (Motion seconded by Dr. J. S. Templeton, Pinckneyville, and carried).

THE PRESIDENT: The next report will be from the Committee on Reports of Standing Committees, Dr. Darwin B. Pond, Chairman.

*Report of Committee on Medical Service and Public Relations*: As set forth in this committee's opening statement, its "principal interest and activity . . . . . has been socialized medicine and the Wagner-Murray-Dingell Bills". This committee's report was written when the Wagner-Murray-Dingell proposals for nationwide compulsory health insurance had progressed to S. 1606, introduced in November 1945, and enjoying the blessing of the President of the United States.

We join the committee in their assumption that this bill will not progress far beyond the hearing state before the summer adjournment of congress. It is pleasing to note that this committee is cooperating closely with the Committee on the Study of Prepayment Plans for Medical and Surgical Care, which during the past two years has been progressively active.

We commend the committee's wisdom in employing, with Council approval, a Director of Public Relations, and we fervently hope this action will be vindicated by results. We desire to heartily approve the work performed by this important committee.

(DR. POND: I move the adoption of this portion of the report. Motion seconded by Dr. W. S. Bougher, Chicago, and carried).

*Report of the Committee on Professional Demeanor*: Reading the report of this committee we were struck by its controversial statements, "The work of the Committee on Professional Demeanor has almost reached the vanishing point. During the past year the Committee has responded to many calls in Cook County from men who were threatened or who had suits already instituted." We are informed that the foregoing should have been worded as follows: "The work of the Committee on Professional Demeanor *outside of Cook County* has almost reached the vanishing point." We believe this Committee should have a more fitting designation than its present name.

(DR. POND: I move the adoption of this portion of the report. Motion seconded by Dr. P. E. Hopkins, Chicago, and carried).

*Report of Committee on Archives*: This proper and touching memorial to Dr. Carl E. Black in the form of a resolution constitutes the Committee's report in its entirety. We are enthusiastically in accord with the resolution to perpetuate the excellent work started and maintained by our beloved colleague, Dr. Black.

(DR. POND: I move the adoption of this portion of the report. Motion seconded by Dr. V. A. McClanahan, Aledo, and carried).

*Report of the Committee on Medical Education and Hospitals*: This exhaustive report, complete with statistical tables, definitely indicates the palpable flaws in the acceleration programs utilized by our medical schools during the recent national emergency. The dark prospect for the procurement of suitable material in adequate numbers to fill the ranks of the medical profession is well stated, and I quote: "Either there will be too few applicants to fill the freshman classes of all schools with adequately trained students, or some school will admit inferior applicants."

We agree with the statement that the projection of government aid to medical students should take the form of loans, rather than scholarships or grants in any other form. The tables presented regarding civil and government hospitals indicates the ebb and flow of their occupancy and is illuminating. However, those tables do not adequately depict the critical shortage of beds in our hospitals.

(DR. POND: I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, Avon, and carried).

*Report of the Committee on Medical Benevolence*: The Committee is to be complimented upon the brevity of its report, and we feel secure in the belief that no committee has such unanimous support and sympathy as our membership accords the Committee on Medical Benevolence.

(DR. POND: I move the adoption of this portion of the report. Motion seconded by Dr. P. E. Hopkins, Chicago, and carried).

Respectfully submitted,
DARWIN B. POND, Chairman
WADE O. HARKER
T. A. LAWLER

DR. POND: I move the adoption of the report as a whole. (Motion seconded by Dr. E. E. Davis, Avon, and carried).

THE PRESIDENT: We will now have the report of the Committee on the reports of Council Committees, Committee "A".

DR. H. A. FELTS: The Committee has gone over these reports but we have not had time to write a formal report. That report will be written and handed to the Secretary. The sense of the Committee is that the reports are all in order and we ask for the adoption of the report. (Motion seconded by Dr. W. W. Fullerton, Steeleville, and carried).

THE PRESIDENT: We will now hear from Committee "B", presented by Dr. G. Henry Mundt.

DR. MUNDT: This is a report on the report of the Committee on the Medical Care of Public Assistance Recipients. I have sat in a number of meetings of this type and I have had reports of committees handed to me and many times I have not read them. I want to tell you if the members of the House have not read this report they have no conception of the tremendous amount of work that was done by this Committee. This is a word picture of the problems with which the Committee has had to deal over a period of several years.

Your Committee commends very highly the report of the Committee on Medical Care of Public Assistance Recipients. We call attention to the break in relations between the Illinois Public Aid Commission and the Chicago Medical Society, and advocate that the Council of the Illinois State Medical Society make further effort to re-establish the proposed relations.

I might say to you that the reason those relations were broken off was because there was a change in the attitude of the Commission on the care to be rendered to recipients in the county of Cook. There is no doubt that the reason that was done was because the Commission argued that we had charity hospitals in this town to which these patients should be sent. However, there has been established in the Commission, as I understand it, a definite attitude that the recipients should not have the privilege of free choice of physician and hospitals, and hence those relations were broken off. If we think these relations can

again be reestablished it would be well. We place no blame on the Committee but I think we should try to do it.

I move the adoption of this report. (Motion seconded by Dr. R. K. Packard, Chicago, and carried).

G. HENRY MUNDT, Chairman
(Signed) CHARLES ALLISON
J. J. MOORE

THE PRESIDENT: The next report will be that of Committee "C".

*REPORT OF SUB-COMMITTEE "C" TO CONSIDER THE REPORT OF THE COMMITTEE TO STUDY PREPAYMENT PLANS FOR MEDICAL AND SURGICAL CARE*

The Committee met at 1:00 P.M. Wednesday, May 16th. Two members of the Society appeared before us and offered certain objections to the policy, the report of the Committee and the insurance carrier as follows:

Certain statements in the literature distributed to the House of Delegates were said to be at variance with the terms of the policy; restrictions in the policy nullify certain other benefits promised by the contract; the policy was said to protect the company over well, the company could decide to cancel existing contracts and refuse to sell others should this prove to be a money losing proposition.

These discrepancies should, of course, be corrected. With this provision, the Committee recommends that the report be accepted; and its proposals followed, in thus taking our first step to establish a prepaid medical care program.

It must be realized that no policy and no plan can be perfect or please everyone at this time, but considering the very able character of the Committee and the intensive study it has made of this subject, it is extremely unlikely that this House could devise a more satisfactory plan at this time. Consequently Sub-Committee "C" suggests the adoption of the report of the Committee to Study Prepayment Plans for Medical and Surgical Care.

Respectfully submitted,
(Signed) C. H. HULICK, Chairman
C. O. LANE
JAMES H. HUTTON

DR. HULICK: I move the adoption of this report. (Motion seconded by Dr. L. J. Hughes, Elgin).

DR. ROLLO K. PACKARD, Chicago: Mr. Chairman and Members of the House of Delegates: I have been one who has long been interested in prepayment medical plans, one that has long been interested in group hospitalization, one that sponsors the work the National Physicians' Committee has done. I believe this House of Delegates has great responsibility and that the decision you make regarding this will be the most momentous decision that this House of Delegates will have made today or in any preceding meeting of the House of Delegates it has been my privilege to attend. I hope that you will bear with me and I will try not to take too much of your time, but I would like to present to this House of Delegates certain facts which I think are quite essential in your determining what action you should take.

First, the American Medical Association has approved prepayment medical plans and has urged that they be on a non-profit basis, that they meet certain standards and requirements of the American Medical Association which I am not going to read because I am quite sure that the members of the House are familiar with those statements. I want to apologize at being forced to mention some names in my discussion. The names I shall mention are personal friends of mine. We have differed before and we have had our arguments, and I am sure that whatever I say will not change that personal friendship. I am only giving to this House of Delegates data as a matter of information.

The House of Delegates approved the recommendation of this Committee at the January meeting. Unfortunately illness prevented my attending that meeting or I might have made some statements then.

I want to call attention to the statement existing in the last issue of the Illinois Medical Journal on Blue Cross Plans and prepayment plans made by Mr. Neal. I tried to contact him yesterday. If he is present in the audience I wish him to feel perfectly free to speak. He states in this report on Page 183:

> Historically, the Blue Cross came into being early in the depression. Insurance Companies were not interested in that type of coverage for two reasons, first they thought hospital insurance could not be written profitably. On the other hand, we were in the depth of the depression and people had no money for such a fool thing as hospital insurance and the insurance company being interested in making a profit, did not go into that coverage. The results in terms of contracts sold since that time have a tremendous amount of significance to me. The Blue Cross Organization in the United States and Canada have approximately 18,000,000 at the present time. The commercial insurance companies did not start in that field of protection until some four or five years later and at the present time they have somewhat in excess of 40,000,000 subscribers. In about two-thirds of the time they have attracted over twice as many subscribers as Blue Cross has been able to achieve. That makes me believe all the more the fact that hundreds of accident and health insurance companies are the ones that will be primarily interested and have the facilities to make this type of insurance available to a much greater segment of the American people than any non-profit organization or combination of non-profit organizations operated in the State of Illinois.

As a matter of fact, I have a policy myself that I took out in 1917 from a commercial carrier which gives me health and accident insurance and some coverage on my hospital bill. They have been writing these policies I do not know how many years but I have one that goes back that far, so that is definite evidence that they have long been interested and have

been writing policies of that type. The last reports issued from statistics in Washington is that they have written prepayment plans for hospital care to exceed 40 million dollars. I mention that not only as a criticism of the report but as an educational fact to aid the members of the House of Delegates in arriving at a conclusion. I also want to refer to a statement in the last issue of the Illinois Medical Journal by Dr. Phifer on Page 184:

> Now, Dr. Hammond referred to the question of a Hospital Service Plan. I have great respect for all Hospital Service Plans but they are not non-profit. I think without question this plan in Chicago has a reserve of a million and a half dollars. The only thing about it that is non-profit is that the Directors do not get paid for attending meetings, otherwise it is all for profit.

I happened to have had the privilege of helping to organize that Plan in Chicago and served on its Board for eight or nine years, and have been a member of its executive board. In the first place the Plan has two and one-half million in securities and today we have 900,000 subscribers. That is sound insurance to have a surplus reserve as all well operated insurance companies have. It is not an argument against the Blue Cross Plans. Let me tell you something more. In this period of time the Blue Cross has never raised its rates to subscribers, but we have constantly increased the benefits as that surplus grew at all times. During that period all forms of service to the hospital have increased 36 per cent without increasing the rates. What he says about the Board of Directors is true. We give our time gladly to the cause we think serves a very definite place in Chicago. I think, Dr. Phifer, in your report you made the statement that commercial carriers had proven that they could underwrite this insurance at a cheaper rate than insurance service plans. I want to spend some little time to tell you what has happened to some of the plans that covered medical, surgical, home and office medical care. One of the first plans in this country to adopt that was the Michigan Plan. After that Plan had been in operation just a period of approximately two years, the Michigan Plan discontinued it entirely because they lost so much money that they could not keep it in effect. I want to give you statistics. The Plan was put in operation in 1940 and was discontinued in 1942. Dr. Harold M. Camp, Dr. E. S. Hamilton, our beloved friend, Dr. John Neal, and myself attended a meeting of the House of Delegates in Michigan and we listened to this program providing for prepayment medical care. Dr. John Neal had had some experience in the insurance business and he was fairly keen minded. He said, the plan will fail. The plan did fail in two years — John was correct. I think we all agreed that the plan was doomed to failure. What actually happened was that they had an income of $183,395, and their payments to physicians amounted to $295,325, with an overhead of $24,000, and the actual loss was $31,000. They discontinued the plan in 1942 and instituted a plan covering surgical care and obstetrical care, and since that time the plan has gone on. They are the largest plan in America today and they have paid back to the subscribers every dollar they lost on the medical care and they have a surplus at the present time, and it is a safe and sound program.

The Buffalo Plan with home and office calls was discontinued January 1, 1946. That sold for $3.00 per month for a family group. Forty-four percent of all plans were for home and office calls. The bookkeeping costs them $2.00 for every $3.00 that was paid. Buffalo Plan discontinued that method. They are going to take care of their old subscribers. They have increased their rate from $3.00 to $4.00 a month and are still taking a loss on that medical program.

In California, one of our large insurance companies, the John Hancock, issued a policy covering medicine, surgery, obstetrics, home and office calls and they charged $6.00 a month, that is $72 a year. They have discontinued it and they took the largest loss on that policy of any contract they have ever issued.

Further, I want to call your attention to the fact that Dr. Phifer stated in his report that they were able only to get one insurance company to write this contract. All the other insurance companies clearly refused to write it except a company in Michigan who was willing to write a contract and charge $10.00 a month because they thought on that basis it might be actuarially sound.

I do not know how many of you people have your contracts with you. On this contract in bold type it states:

> This policy provides indemnity for surgical or medical expense actually incurred, caused by bodily injury effected by accidental means, or by sickness, for which compensation is not payable under any workmen's compensation or occupational disease law, to the extent herein limited and provided.

That is in big bold type. That is what the salesman sells this policy on. I want you to go down and listen to this statement. This policy has been advocated because downstate doctors wanted a policy that covered office calls and home calls.

> *Medical Expense*: . . . . . the Company will pay toward the expense of such medical treatment up to $3.00 per treatment at home and $2.00 per treatment at the hospital or at the doctor's office (limited in any case to one treatment a day) not to exceed as the result of any one accident or any one sickness, the sum of One Hundred Fifty Dollars ($150.00). In case of bodily injury such payment shall begin with the first treatment and in the case of sickness shall begin with the third treatment and continue only during the period that such sickness necessitates continuous total disability.

I want to ask the members of this House of Delegates what percentage of patients that you see in your office are totally disabled. I believe you will agree that about 95 per cent of them are working. That is a statement that I think is misconstruing to the public and it should not be issued in this policy.

I want to call your attention to another statement in the policy.

> *Article II. Surgical Expense.* If any member of the Family Group by reason of injury or sickness as described in Article I, undergoes an operation named in the Schedule of Operations appearing herein, and such operation is performed by a duly licensed surgeon, within ninety days from the date of accident or commencement of sickness, the Company will pay the surgeon's fee up to the amount specified in the Schedule for such operation. If more than one operation be performed on account of injuries sustained in any one accident or on account of any one sickness, the limit of payment shall be the largest sum specified in the schedule for any one of the operations so performed.

That is worthy of some serious consideration. Gastric ulcers that are diagnosed and are not operated; the medical man may treat them two, three, four, five, six or seven months or a year, and then find that it is one of those cases that does not respond to medical care and will recommend operation, but under this policy the company will not pay for this operation. Gallbladder disease, many people have a history of gallbladder disease which dates back twenty years. Maybe they are having more trouble and operation is recommended. Under the terms of this policy if it cannot be established that the disease began within ninety days of operation, they will not pay for the operation.

We talked about professional relationship and that it must be maintained, and that the doctors should have complete control under this policy. I want to read you under standard provisions, No. 8.

> The Company shall have the right and opportunity to examine the person of the Insured or other member of the family group hereunder when and so often as it may reasonably require during the pendency of claims hereunder, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

That does not retain professional relationship at all.

In the Illinois Plan of Prepaid Medical and Surgical Insurance there is one thing I want to mention:

> G. Indemnity up to $15.00 should be included to cover the cost of necessary X-ray work, either in office or hospital.

That is a pretty small fee for the low income group if they have to have medical care.

> H. A reasonable indemnity should be provided to cover such costs as blood chemistry, electrocardiogram, basal metabolism, etc.

I will read you what the contract says. The contract states definitely that x-ray will be provided for up to $15.00. There is no provision for basal metabolism, clinical pathology or laboratory work of any kind. At the bottom of the sheet containing these principles it states: "The foregoing is approved and accepted: (Name of Insurance Carrier) By ....." That does not mean anything because the insurance carrier will pay only for what is in his contract and that is why he puts in all these stipulations.

Here is some literature that is going to be passed on to the public. Under Benefits they outline certain things and they come down to this statement:

> ..... or for non-surgical service, in home, office or hospital, up to $150.00 for any one accident or disabling illness, on the basis of $3.00 per home treatment, or $2.00 per office or hospital treatment. Medical benefits begin with the first treatment in case of accident and with the third treatment in case of illness.

There is no mention in this literature handed to the public that they have to be totally disabled to collect under this policy. I believe it is a dangerous thing for the profession to issue statements in their literature that are not contained in the body of the policy so that the public know exactly what is in the body of their contract.

I would like to further state that on the cover of this literature it states:

> The Illinois Plan of prepaid medical and surgical insurance accepted and approved by the Illinois State Medical Society.

I do not know anything better that a salesman wants than that type of thing. I think this is contrary to insurance laws.

Having made this discussion and given you these facts I want to say, I have no quarrel with indemnity insurance. All I am appealing for is an honest contract that is actuarially sound and that is not misleading to the public. Some people have said, let them try it, if they fail you have not lost anything. I want to tell you something, that when you have tried something today and that has failed you have lost something. In Washington when a plan fails the proponents of the Murray-Wagner-Dingell bill say, "yes, this is proof that the medical profession cannot do this job." It is the responsibility of this House of Delegates to the people of Illinois that we must think about.

I should like to offer an amendment to be written into this contract. On the top line where it states, "This policy provides indemnity for surgical or medical expense actually incurred, caused by bodily injury effected by accidental means, or by sickness, for which compensation is not payable under any workmen's compensation or occupational disease law, to the extent herein limited and provided", add *"only in case of total disability"*, in the big bold type that the rest is printed in, so that everybody sees it at a glance.

Under Article II, Surgical Expense, I should like to delete that portion that states "within 90 days from the date of accident or commencement of sickness". That should be taken out of this contract. A patient with a gallbladder disease or ulcer has a right to be paid under the contract and yet his symptoms often have been present for years before operation.

Under Article III, Medical Expense, where it states, "In case of bodily injury such payment shall begin with the first treatment and in the case of sick-

ness shall begin with the third treatment and continue only during the period that such sickness necessitates continuous total disability", I should like to amend the policy, omitting the words, *"and continue only during the period that such sickness necessitates continuous total disability"*, so that the contract will correspond to the literature (the yellow sheet handed to the members of the House). If we are going to give them medical care let us be honest about it.

Under Standard Provisions, No. 4, I should like to substitute *thirty days* in place of twenty days after the date of the accident causing such injury or within *twenty days*, instead of ten days, after the commencement of disability from such sickness.

Under No. 8,

> The Company shall have the right and opportunity to examine the person of the Insured or other member of the family group hereunder when and so often as it may reasonably require during the pendency of claim hereunder, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

Mr. Chairman, I move the acceptance of these amendments. (Motion seconded by Dr. Harold W. Miller, Chicago).

THE PRESIDENT: The amendment has been made and seconded, it is now open for discussion.

DR. E. S. HAMILTON, Kankakee: I would like to know how the amendment affects the motion. Could I hear the original motion made by the Committee?

DR. PACKARD: I assume the fee schedule is part of the report. Dr. Hamilton, we are interested in principles. I think this House of Delegates has a right to vote on this fee schedule, and to vote on this amendment. I shall feel very badly to see these things left in the contract.

THE PRESIDENT: In the report of the Committee on the Study of Prepayment Plans there is no reference to the fee table.

DR. HAMILTON: Mr. Chairman and members of the House: I am speaking not as a member of the Committee but as an individual. I wish to reciprocate all the kind things that Dr. Packard said about me. I am a very good friend of his and I shall still be a good friend of his when I get through, at least as far as I am concerned.

I agree with Dr. Packard that principles are of paramount importance in this thing. I think it is a grave mistake if we allow any personal feelings to enter into this thing. I regret very much that Dr. Packard was not at the meeting in January; his health did not permit it. That was unfortunate for all of us. I also appreciate very much that Dr. Packard did not mention my name in his talk. Apparently I did not talk enough to get into print. What we are most interested in is not to quibble about details. I think Dr. Packard has some good points. I think if he had come to the Committee and discussed those things many of them would have been included.

DR. PACKARD: I would like to inform this House of Delegates that I personally appeared before this Committee yesterday for two and a quarter hours and I talked about the very things I have today. Is that not correct, Dr. Hulick?

DR. HAMILTON: Had he come before the Committee on Prepayment Plans I am sure he would have received a very kind reception. I am sure we would have done that for Dr. Packard. We have interviewed practically everybody in the state of Illinois. I have no quarrel with Dr. Packard. If there are irregularities in the contract and the propaganda they should be corrected and I assure you they will be corrected if it is within my province to see that they are corrected. However, again I say that that is not the important thing. The important thing today is that we get a plan in operation. The sooner we get a plan in operation the sooner we are going to begin to do something besides talking. Two years ago we started talking in our organization on the subject and today we have written very few policies. I do not want to disagree with Dr. Packard about any of these things. There are things he said that if he is correct, I have been misinformed. I think they should be given consideration again either to corroborate what he said or deny his assertions. That is the American way. I am sure you would say he has labored long and apparently brought out a mouse. I have attended somewhere between forty and fifty meetings of this Committee here in Chicago in the past two years; I deserve no credit, I enjoyed the situation and it has been a liberal education. I regret exceedingly that we have accomplished nothing. If it is the pleasure of this group that Dr. Packard's motion to amend the policy be drawn up, I will prepare the only objection I have on constitutional grounds. We should decide this today when we are dealing with a practicality and with only the view of what is good for the medical profession and the public in Illinois. I am not interested in any defense or commendation of the Blue Cross. They have done a swell job in Illinois and they have done a swell job all over the United States. That is beside the point of what we are doing here today. I appeal to you gentlemen to think of what is good for the medical profession and the public in Illinois, and if it is not applicable to some particular part of the state under the enabling act, they can do what is good for their particular part of the state. Let us have unity. Let us have one plan in Illinois but let us have it now.

DR. JAMES H. HUTTON, Chicago: I was one of the Sub-committee. I was not a member of the committee that made this study of prepayment plans. Dr Packard appeared before us yesterday. Let me read our report. (Rereads the report of the Subcommittee). Two members appeared before us and stated some objections to the report of the committee concerning insurance carriers. Dr. Packard spent about an hour and three-quarters. He took nearly that time this morning. He qualified himself as an expert. I would not challenge that at all. I think he has made a very

extensive study and a very good study. I think it is unfortunate he did not work with the committee that made the report. Our report was only on the report written in the handbook. He indulged a little bit in controversy. This House of Delegates meets annually, but it has happened only to have met once in two years. Most of its business as of necessity has to be carried on through committees. If the members of this House could have attended all the meetings of this Committee for the Study of Prepayment Plans the House might or might not have arrived at the same conclusions that the Committee arrived at. That was a very able committee. They made an extensive study and devoted a staggering amount of time and effort to it. I take it that all members of the Committee do not approve all the things presented but we gave our report. We say, "it is extremely unlikely that any group of the House of Delegates can devolve a plan or policy or contract that would be completely satisfactory to everybody concerned." This one is not completely satisfactory to a great many people. We would not expect it to be. It is entirely unlikely that this House of Delegates sitting in this morning for an hour or two or three or four hours could evolve any better plan than proposed here. This is a plan that has been evolved after two years of study. It seems to me we would be very wise not to take this one step. Life is a thing we take chances with. We have to take chances with this.

Dr. Packard criticized the policy. That was not the matter that we were considering. We did talk about it yesterday. I think some of his criticisms are on parts of the standards in policies. I would like to know how many members understand all the provisions of their insurance policies.

DR. K. B. RIEGER, Freeport: I have been associated with an insurance company for eighteen years and I think I am well acquainted with the provisions in all the policies they put out.

DR. HUTTON: I am sure I do not understand all the policies I have; quite often they turn out to be more liberal than I thought they were. This larger committee is as able as any committee that could be appointed. It has devoted a staggering amount of time and energy to this subject. They have made certain recommendations and I think they should be followed.

THE PRESIDENT: If there is no objection I will ask Mr. John Neal to discuss this question.

JOHN W. NEAL: Mr. President and Members of the House of Delegates: I was not aware that I was to be called on. I made a few notes as Dr. Packard was speaking. Just from the standpoint of clarity I would like to say a few things.

The plan which has been placed in operation is not entirely experimental by any means. It was pointed out that the Michigan Medical Service and other Plans have undertaken to cover medical care in the home and office, have had difficulties and many of them failed. Bear in mind that a plan which is being operated under the auspicies of the state medical society is 98 per cent sound. In comparing this with the one being operated in Winnebago County, during the first twelve or fourteen months of operation in Winnebago County the experience was such that the Company was able to increase the benefits detailed in their policy without an increase in costs. Specifically, they increased the amount of indemnity for home calls from two to three dollars; they increased the benefits detailed for pregnancy, abortion or miscarriage from $35 to $50, and they have made one or two other pertinent changes in coverage. I do not mean to infer that because of that experience the plan is steady or that failure is impossible, but I simply want to point out that it is not experimental. The experience has been favorable from the standpoint of the insurance carrier and to the very best of my knowledge highly satisfactory to the Winnebago County medical men. If I am not correct I would appreciate any member from that county correcting me.

Again, a great many of the provision to which Dr. Packard objected, such as ninety days from the commencement of illness, and written notice twenty or ten days after beginning of accident or illness, are standard provisions and they are required by law to be in the various contracts. They were taken verbatim from the Illinois Insurance Code. They cannot be changed regardless of how much we would like to unless we can amend the Illinois Insurance Code.

It is true that Dr. Packard did call me many weeks ago and ask me whether in my judgment a cash indemnity plan as opposed to a service plan could be operated under the enabling act. It is true I told him in my judgment we could not know that until it had been adjudicated by a court of competent jurisdiction. I was inclined to believe that the legislative intent in adopting that act was to permit only service plans operating in the same manner as the Blue Cross. I could be wrong — any lawyer can be wrong. The Chief Legal Counsel for the Illinois State Medical Society has rendered us an opinion that a cash indemnity plan could probably not be instituted under the Illinois enabling act legislation. I want to conclude simply by saying this. After devoting a great deal of time, as has been said before, to the study of this problem, I think it was the feeling of the Committee that whether it should be operated not for profit or for profit was of secondary importance. The important thing was to make coverage available and to make coverage available of sufficient scope to be of general advantage to the average wage-earner and to make it available at a price where the average individual could not only afford to pay it but could be induced to pay. The absence or presence of a profit motive in this type of plan seemed to be of secondary importance, with this exception, if we say it must be non-profit then we have ruled out every insurance company in the country which operates for profit, and we have said in effect that we do not want the assistance and experience of the gigantic American insurance industry to stand side by side with us against the Murray-Wagner-Dingell bill. It would be most unfortunate to rule out any legitimate effective agency from bringing a prepayment

medical plan to the public. If it can be done on a profit basis fine; if it can be done on non-profit basis fine. The important thing is to have it done.

DR. CHARLES H. LESAGE, Dixon: There are three doctors from Winnebago County on whom you can call in order to get some points about the plan in their county.

DR. EDWARD H. WELD, Rockford: In Winnebago County we felt we ought to do something about a prepayment plan. We started on it about three years ago and we threshed it over for about a year. We got in a hurry and thought we wanted to do something right away. We finally came to the conclusion that we would start. When we first started out we did not have an enabling act which was disappointing. After we got the enabling act and studied it we thought that probably our best plan was to let an old line insurance company handle this for us. After going over the matter with various insurance companies we finally decided upon one which we selected. We laid down certain basic principles in which we said that any company can come in and write that insurance if they followed those basic principles. In other words, we are not definitely tied up to any one company. Our experience out there on the whole has been good. I understand that we have a few over 4,000 policies that have been sold at the present time. I do not believe there has been an extensive push behind this for the insurance company to sell this policy. I do not know their exact reasons. I know one reason and that is, that they told us flatly that this was on an experimental basis. I understand that at the conclusion of the first year they did increase the benefits without increasing the price. I think we have all been a little bit up in the air about what was going to happen, not only the medical profession about prepayment plans but employers have had a problem not knowing what the government was going to do and what their labor organizations were going to require of them. Consequently, the insurance company has had to feel its way along before they put on an intensive campaign. My understanding is that in Winnebago County this old line commercial policy has been a success.

DR. K. B. RIEGER, Freeport: I heartily agree with everything that Dr. Packard said before this House of Delegates concerning the changes that should be made in the policy by the carrier. This is not the only company that is writing this type of insurance. There is also a policy written by the Continental Casualty Company under the title of the Blue Banner, though there are some minor changes in the size of the fees. I do not think they provide for house calls but they do provide for hospital calls. That is written for the sum of $2.00 a month for a family in contrast to $3.25 that we are considering at the present time. Though they have had a year or two experience in Winnebago County, I think that the experience has been sufficient to justify them to go ahead. I think we should make the readjustments Dr. Packard suggests. This is a very limited type of policy and those changes should be made.

DR. CHARLES H. PHIFER, Chicago: I do not want to enter into a controversy. I have the highest regard for everyone who has discussed the report. In answer to Dr. Rieger, the Continental Casualty people were in before us. They were very anxious to complete a program with us, only they signed up with the Northern Illinois Hospital Association. The Northern Illinois Hospital Association soon found themselves in trouble to this extent, under their limited enabling legislation they cannot operate that program.

Regarding the statement of Dr. Packard regarding non-profit, Mr. Ketchum and Dr. Feierabend, whom you heard at the January meeting, were on the A.M.A. committee and there was also added a man who represented a plan sponsored by a commercial carrier. Those three men were drawn into this picture in the Advisory Committee.

DR. P. E. HOPKINS, Chicago: Mr. President and members of the House of Delegates: I would like to correct a statement inasmuch as Dr. Hutton gave the House of Delegates credit for appointing this committee. The Committee was appointed by the Council, according to the motion of Dr. Packard passed by the House of Delegates in 1944. An effort was made to bring together on that committee men of the medical profession in all fields. We have men who are interested in education, who are interested in industrial work, men who are interested in private practice, men interested in the specialties, among whom our worthy President-elect who has served for some years as a member of the Board of the Plan for Hospital Care, the Blue Cross Plan in Illinois. I am sure that the Committee has every desire to provide the greatest amount of coverage. The Committee is not interested nor will it countenance if it is aware of it, anything that may be sold under false pretenses. I am sure you gentlemen have enough confidence in your Committee to realize that they will do the right thing. It seems to me, and I have sat in on practically all the Committee meetings as an ex officio member that the Committee will be glad to take advantage of the criticisms that have been offered by Dr. Packard because I am sure they are interested in providing the best policy they can provide. On the other hand, it occurs to me that this particular policy which is the only one that the Committee hopes to present to the people of Illinois, is not the primary thing up for consideration this morning. It is the only policy they have seen fit to approve.

DR. PHIFER: May I add one word. There has been some comment on the question of commercial carriers. The Bulletin of the Public Relations Committee of the American Medical Association under date of April 22 has appended to it a comment from the Health and Accident Underwriters Conference which has been in conference with this group, to this effect: "The American Medical Association's plan is being carried out; it sets forth the standards for medical care plans which must be carried out in order to have the plan approved. These include free choice of physician. If some thought had not been given to the use of commer-

cial carriers certainly those two companion pieces would not have gone out together.

DR. HAROLD W. MILLER, Chicago: I do not want to take up a lot more time because I know the hour is getting late. Having been on the Committee from the Chicago Medical Society for a couple of years with the group that has been studying prepayment plans, I would like to say a few things in behalf of our work. On account of the fact that we have had a good deal of knowledge from time to time of the State Council Committee, I know the immense lot of work that these men have done. There is no question about it. I approve in the main of much they have done. The time has come we all feel that we must have some sort of prepayment plan if we are to do anything regarding the Federal Government's plan to install Federal insurance and social insurance. We have waited perhaps too long. We have been thinking about it, but the rule is that doctors are too busy to do other than take care of their own immediate practice and their own necessities of life. We have set aside that work to others. We have let the insurance companies come in and write such policies as they have felt they desired to do. The fact is, that in speaking of non-profit organizations throughout the country there are thirty-five states that have prepayment plans run on a non-profit basis. There is only one state at the present time — at least that I am acquainted with — that has a prepayment plan authorized or run by a commercial insurance carrier. That state is Wisconsin. However, not all of the Wisconsin medical men felt they wanted to go along with this plan so the Milwaukee County Medical Society did not second the state's effort in this behalf and they have organized their own prepayment plan and they placed it in the hands of the Blue Cross to do the office work and sell it.

The Chicago Medical Society's Committee have devised a plan which is governed entirely by the doctors, that is, it is proposed that we will govern it entirely through a committee of nine and it is to be run on a non-profit basis. We do not feel that money lies; money goes just so far. We cannot see how a commercial or old line insurance carrier can furnish the same kind of service to patients and at the same time pay as much to the doctor as a non-profit organization can do if run on a proper basis. The mere fact that thirty-six states have already instituted plans and most of these plans are in working order, are getting along in good shape and are functioning, and that all of these are working with non-profit organizations such as the Blue Cross, should support our contention that this can best be done by a non-profit organization. The Chicago Medical Society's Committee, with this knowledge in hand and because of the time element, does not feel that at this late date we should go along and undertake something that we do not know much about, something that has not been accepted by the majority of the states.

I am glad to hear that Winnebago County has gotten along so well. The statistics on insurance companies or plans that have been put out, that paid two or three dollars for house or office calls, show that these plans have not heretofore lasted very long unless the premium was increased to warrant such payments, certainly not on $1.00 for the head of the family and $1.50 for the wife and children.

I do not think that it would aid us at this time to take that one step that Dr. Hulick's motion calls for unless we are absolutely all in accord. If we start something and fail, it is a black eye. I do not feel it is necessary to fail. There are too many examples all about us. There are too many plans that are working well and working well with non-profit organizations. The Blue Cross has had plenty of experience in hospital insurance. It is not so different for a medical plan. The principles in running a company or plan are practically all the same. So before adopting this wholeheartedly I feel as many of you do, that certain corrections must be taken care of and certain things must be changed. I wish you would weigh very carefully the advisability of a commercial insurance company's handling it entirely. I think it should be placed definitely with a non-profit organization.

DR. PACKARD: I am very sorry that Dr. Hutton feels that I have taken too much time, but if the Committee has taken two years, I can take two hours to decide this very important question.

I think some one — my good friend Ed Hamilton — thought it was unfortunate that I had not attended the meetings of the Committee for the Study of Prepayment Plans. I would have been happy to have gone to a meeting but I was not invited. I would like to remind Dr. Hutton that I did not appear before his committee as an expert. After we had thoroughly discussed this program Dr. Hutton asked me something about the Chicago program. I said I was not a member of the committee but they called me in for advice — and I hope some people can take a joke without taking it too seriously. I have no objection to the Committee. I raised all my objection to the Committee in perfectly good faith. I want to tell you something further. I have never objected to a commercial carrier or to an indemnity plan of insurance. I still do not object to a commercial carrier or an indemnity plan. All I want to know is that the plan covers what the medical profession wants and that it is actuarially sound. I only made these comments. I have not asked you to turn this contract down. I have only objected to certain portions and so moved an amendment that will correct certain things in this contract that I sincerely feel should be corrected.

DR. HULICK: In our report we covered most of these things. Possibly they were not heard. I would like to read the report again.

(Reads the report of the Reference Committee).

DR. FRANK P. HAMMOND, Chicago: I also feel that this question is of momentous importance to the Illinois State Medical Society. I hope that the Chair and the House will give ample time for sufficient discussion. The amendments that Dr. Packard has recommended were all in the report of the Reference Committee as Dr. Hulick just read. It states, "these

discrepancies should be corrected." Later on the Committee recommends the adoption of the report, that is the report of the Committee on Prepayment Plans for Medical Care of the Illinois State Medical Society. Since the Committee recommends that these discrepancies should be corrected and Dr. Packard has called attention to the discrepancies in regard to the literature being put out to the public and also features of the contract that are not medically sound, because we all know that the limitations of diseases — many of them in the vital organs of the body, stomach, gallbladder and pancreas — should be eliminated. Since the Committee recommends that these discrepancies should be corrected, I hope this House will approve this amendment and will pass it, so what the Medical Society puts out to the public will not be a discredit to them and so the Medical Society will not look as though they have not gone into it thoroughly.

If Mr. O'Neal is still here, I would like to ask him if in the insurance department's code these stipulations that you must wait ten days on accident or twenty days in illness, are not intended as the minimum stipulations. Is it not true that if you provide more benefits to the policyholders in this state the insurance department will not object?

MR. NEAL: I think that is true.

DR. HAMMOND: Mr. Neal mentioned that these were stipulations in the insurance code but neither do they object if you want to give more than the policy states. Mr. Neal refers to the American insurance fraternity. Not more than ten days ago I reviewed a letter prepared for publication by one of the largest insurance companies in America to be published in the Insurance Journal; this letter appeals to the insurance fraternity to cooperate with hospital insurance plans in providing this country with insurance. The insurance companies are more friendly than they were in the beginning. We realize that that field is a great one and they want to cooperate. I want to bring that up and to correct the thought that if we do not use a commercial carrier we lose the cooperation of the insurance companies. Here is one of the largest insurance companies to whom prepayment plans were presented; the medical director said, there is a move by a national organization (and that was the American Association of Industrial Physicians and Surgeons) to establish a national medical plan, but when the American Medical Association came along and took up this matter we were all happy about it, and that Association (A. A. I. P. S.) relinquished its interest for the present time. When this medical director spoke to the managing director and said the doctors were figuring on putting it on, he asked the question, because he had some doubt about the relationship to the insurance company, and said, "it is certainly time that the medical men were looking after their own business." Medical control is important in my estimation. I mentioned at the time of the meeting of the House of Delegates on January 6 that the rates, benefits and charges can be set by the medical profession and the Board of Trustees if you incorporate a plan of your own. Any medical illness can and should be covered. There should be some statement that any operation or illness on the list will be handled. The third point is that the money that comes in on the program should be paid back in benefits and the expenses to operate the organization should be held to a minimum. Dr. Harold Miller told you there were 35 medical plans. I would like to correct his statement. He said 35 states; it is not 35 states, it is 35 medical organizations, some are county. Thirty-five have incorporated and sponsored medical plans under their control. The plan will be under their control from time immemorial. Those 35 medical societies in this country it seems to me should be an example and a criterion for the action of this House of Delegates. I am here speaking in favor of the amendment. I believe that we should all approve this amendment, so that there will be no reaction, no reflection upon the integrity and upon the business acuity of the medical profession.

THE PRESIDENT: I want to ask Mr. Neal for one opinion. Dr. Packard has made certain recommendations that changes be made in this policy. This House of Delegates approved the action of the Committee and instructed them to go ahead and make a contract. This contract has been made. Is it possible to institute any or all the changes in this policy without invalidating the contract? Can the Company be induced to make certain changes of their own volition that Dr. Packard and the other members feel are advisable?

MR. NEAL: There are two parts to the answer. First, I have not the slightest doubt that the Company would be very happy to discuss it. What they would do I cannot speak for them. Such changes as might be agreeable still would have to be passed upon by the State Department of Insurance. Any change which the Society and the Company agree on and which the State Insurance Department approves can be made.

THE PRESIDENT: Under that statement an amendment of this type might be acceptable and could be worked out with the Company?

MR. NEAL: It could be discussed with the Company but only the Company could commit itself to what it is willing to do.

DR. HAMILTON: Then there might have to be renegotiations and report.

DR. JOHN P. O'NEIL, Chicago: In the event that the Company would not accept them, then we have no medical control of the Company.

DR. HUTTON: It seems to me that the report presented by the special Committee has not been fully understood. I have talked with Dr. Packard and he and I do not understand each other. There was no objection on my part or on the part of any of the Committee to what Dr. Packard said. The special committee tried to provide certain safeguards. We called attention to three categories of objections which Dr. Packard has stated. The report stated that these discrepancies should be corrected and with those pro-

visions the committee recommended the adoption of the report of the Committee. It would be left to the committee, Dr. Packard and other interested persons to iron out the details which we have been discussing.

THE PRESIDENT: We are voting on Dr. Packard's amendment. Dr. Packard will you restate your amendment.

DR. PACKARD: I want to say again that my chief interest is in something that is workable and something that is equable. I am glad if we can still sit down and talk about it. That is the best that can happen in a democracy. I offered these same objections to the committe yesterday. The committee agreed on these objections and recommended that those changes be made. If that is true, then I have nothing more to say because it answers the problem. I want to say furthermore that I will be glad at any time that the State Committee would like to invite me in, to come in for discussion of the carrying out of the details of the recommendations. I will be more than happy to sit in with them at that time. I shall restate the amendments.

1. On the top line where it states, "This policy provides indemnity for surgical or medical expense actually incurred, caused by bodily injury effected by accidental means, or by sickness, for which compensation is not payable under any workmen's compensation or occupation disease law, to the extent herein limited and provided", add *"only in case of total disability"*, in the big bold type that the rest is printed in, so that everybody sees it at a glance.

In the Chicago Tribune of yesterday it states that this plan takes care of home and office calls. The fact is that we do not cover them because there is the restriction that you must be totally disabled. I recommented that that statement, "only in case of disability," be included.

I will withdraw the portion relating to changing 20 and 10 days to 30 and 20, if that is a provision in the insurance law.

2. Under Article II, surgical expense, I should like to delete that portion that states "within 90 days from the date of accident or commencement of sickness."

3. Under Article III, medical expense, where it states, "In case of bodily injury such payment shall begin with the first treatment and in the case of sickness shall begin with the third treatment and continue only during the period that such sickness necessitates continuous total disability", I should like to amend the policy, omitting the words, "and continue through total disability", so that the contract will correspond to the literature.

4. Under No. 8, standard provisions, "The Company shall have the right and opportunity to examine the person of the Insured, etc.", should be entirely deleted. I ask that it be deleted because if this contract is put into effect, you still have an advisory committee and if there is a question it can be referred to the Advisory Committee, if we want to maintain physician-patient relationship.

DR. L. J. HUGHES, Elgin: In view of the fact that this committee has accepted the recommendations of Dr. Packard is it necessary to vote on the amendment?

DR. HAMMOND: If you read the committee's report, it states,

> These discrepancies should of course be corrected. With this provision, the Committee recommends that the report be accepted; and its proposals followed, in thus taking our first step to establish a prepaid medical care program.

The Committee's report should have these stipulations in it as amendments or recommendations.

DR. C. P. BLAIR, Monmouth: Do all the things that Dr. Packard read constitute the amendment?

THE PRESIDENT: Those changes he just presented represent the amendment. Are you ready to vote on the amendment?

(The amendment was voted on and carried).

Are you ready to vote on the original motion as amended?

(The motion as amended was carried).

## *REPORT OF COMMITTEE "D" ON REPORTS OF COUNCIL COMMITTEES*

1. *Committee on Rural Medical Service*: We are thoroughly in accord with the attitude of the Rural Medical Service Committee toward the Wagner-Murray-Dingel Bill. It is believed that the question of rural medical care will be adequately decided locally. With all the outside pressure being brought to bear on this subject, this Committee has a most important function to perform, and is doing it well.

2. *Industrial Health*: On studying this report, it can be seen that the Committee definitely is alert to the work before it, and is to be very favorably complimented for its complete report.

3. *Ethical Relations*: It is noted that there was no work in the past year for this Committee. The doctors who remained at home are to be congratulated for limiting the fighting to those in the Armed Forces.

4. *Maternal Welfare*: We concur in the Committee's opposition to the Pepper Bill and the extension of the E.M.I.C. program, as embodied in it. It is strongly advised that the suggested refresher courses be carried to completion, and it is hoped that an Illinois State Obstetrical Society, for the benefit primarly of the men doing obstetrical practice, be formed. This Committee is doing a splendid piece of work.

5. *Veterans' Service Committee*: It is gratifying to see this Committee again active. This Committee is attempting to carry out a very constructive program, that of raising a fund to assist the needy dependent children of medical officers lost or disabled in the service of our country. We wish them success.

Respectfully submitted,
(Signed)
CARL F. STEINHOFF, Chairman
D. B. FREEMAN
A. C. TAYLOR

DR. STEINHOFF: I move the adoption of the report.

(Motion seconded by Dr. C. M. Fleming, Rushville, and carried).

THE PRESIDENT: We shall now have the report of Committee "E", to be presented by Dr. J. S. Templeton.

*REPORT OF SUBCOMMITTE "E"*

Mr. Chairman and Members of the House of Delegates: Subcommittee "E" wishes to report as follows:

*Cancer Control*: We recommend that the report of the Committee on Cancer Control be accepted. We commend the Committee for their excellent report and also extend congratulations to the various Cancer organizations for their cooperation.

DR. TEMPLETON: I move the adoption of this portion of the report. (Motion seconded by Dr. D. B. Pond, Chicago, and carried).

*Tuberculosis*: We recommend that the Committee's report on Tuberculosis be accepted with the suggestion that the medical profession should cooperate fully with the Veterinarians of the state in their efforts to eliminate bovine tuberculosis.

DR. TEMPLETON: I move the adoption of this portion of the report. (Motion seconded by Dr. D. B. Pond, Chicago.)

DR. C. H. LESAGE, Dixon: I believe there is an error in the report of the Committee on Tuberculosis. It states: "The Department of Public Welfare is making a study of tuberculosis in the insane and penal institutions of the state." I would like to state that the Department of Public Welfare has had very active plans for the care of inmates.

THE PRESIDENT: With the report as corrected, are you ready to vote? (Motion carried).

*Venereal Disease Control*: We recommend the report be accepted and wish to compliment the Committee on their comprehensive effort.

DR. TEMPLETON: I move the adoption of this portion of the report. (Motion seconded by Dr. C. M. Fleming, Rushville, and carried).

*Interprofessional Relations*: The report of the Committee on Interprofessional Relations does not raise any controversial issues. We therefore recommend that it be accepted. However, we suggest that steps be taken to promote closer cooperation between Medicine and all allied professions, notably the dental, pharmacy, and veterinary professions.

DR. TEMPLETON: I move the adoption of this portion of the report. (Motion seconded by Dr. D. B. Pond, Chicago, and carried).

*War Participation*: There is little to say on this subject and we recommend that the report of the Committee be accepted.

DR. TEMPLETON: I move the adoption of this portion of the report. (Motion seconded by Dr. J. J. Moore, Chicago, and carried).

*Constitution and By-Laws: State Society Constitution*: Article IV, Section 1: We recommend that the section read as recommended, except that the word "residency" replace the word "resident". In other words, Article IV, Section 1, should read: "This Society shall consist of members, emeritus members, residency members, honorary members and guests."

DR. TEMPLETON: I move the adoption of the amendment to Article IV, Section 1. (Motion seconded by Dr. R. H. Hayes, Chicago, and carried).

*Article IV, Section 2*: We recommend that the proposed changes be not adopted and that the section remain as it is.

DR. TEMPLETON: I move that Section 2 be not amended. (Motion seconded by Dr. D. B. Pond, Chicago, and carried).

*Article IV, Section 3: Emeritus Members.* No change. We are in favor of this portion of the report.

*Article IV, Section 4*: We recomend that the following replace the wording in this section in the report of the Committee:

"Two years after being licensed to practice medicine in the State of Illinois a physician serving full time as a resident or fellow in an approved hospital in the State of Illinois may enjoy all the privileges of full membership at a special rate up to five years after graduation in medicine. Thereafter the full rate shall apply. The special rate shall be one-half of the per capita amount fixed by the House of Delegates for members. A resident member must have a Degree of Doctor of Medicine or its equivalent, must be a member in good standing of his component society and must be a citizen of the United States."

DR. TEMPLETON: I move that this amendment to Article IV, Section 4, be adopted. (Motion seconded by Dr. R. H. Hayes, Chicago, and carried).

The present Section 4 should become Section 5 and Section 5 should become Section 6. We approve this portion of this report.

We recommend that the change in Article IX, Section 1, referable to officers, shall stand as written by the Committee.

DR. TEMPLETON: I move this portion of the report be adopted. (Motion seconded by Dr. R. H. Hayes, Chicago, and carried).

We recommend that the change in Article VII, Section 1, referable to the Council, shall stand as written by the Committee.

DR. TEMPLETON: I move the adoption of this portion of the report. (Motion seconded by Dr. R. H. Hayes, Chicago, and carried).

*Model Constitution for County Societies*: The proposed change in Article III concerning eligibility is automatically eliminated by throwing out the proposed change in Section 2 of Article IV of the State Society Constitution. Therefore, we do not approve the recommendation of the Committee.

*Model by-Laws for County Societies*: The proposed change in Section 5 of Chapter 1 is automatically eliminated by throwing out the proposed change in Section 2 of Article IV of the State Society Constitution. Therefore, we do not approve the recommendation of the Committee.

DR. TEMPLE: I move the adoption of the report on these two items. (Motion seconded by Dr. W. O. Thompson, Chicago, and carried).

Respectfully submitted,
(Signed)
J. S. TEMPLETON, Chairman
W. O. THOMPSON
F. M. HAGENS

DR. TEMPLETON: I move the adoption of the report as a whole. (Motion seconded by Dr. F. M. Hagens, Lincoln, and carried).

THE PRESIDENT: We are ready now for the election of three new Councilors from Cook County.

DR. P. E. HOPKINS: I wish to nominate Dr. Wade Harker for one year.

DR. J. J. MOORE: I wish to nominate Dr. Leo P. Sweeney for two years.

DR. R. H. HAYES: I wish to nominate Dr. H. P. Saunders for three years.

DR. HOPKINS: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for the three gentlemen named. (Motion seconded by Dr. R. H. Hayes, Chicago, and carried).

(The ballot was cast and the President declared Drs. Harker, Sweeney and Saunders elected for terms of one, two and three years respectively).

THE PRESIDENT: We shall now have the report of the Committee to receive and report on reports of the Editor, Committee on Scientific Work, and the President of the Women's Auxiliary, Dr. O'Neil, Chairman.

## *REPORT OF COMMITTE TO RECEIVE AND REPORT ON THE REPORTS OF THE EDITOR, COMMITTEE ON SCIENTIFIC WORK, AND THE PRESIDENT OF THE WOMEN'S AUXILIARY*

*Women's Auxiliary*: First, they merit unstinted praise for their continued activities during the trying war time years. Most of the physicians being in service, this avenue of information as the political and legislative activities transpiring in Springfield and Washington was denied them.

What we now suggest, in no manner is to be construed as a criticism of the Auxiliary, but we do believe the society should, with increased determination, concentrate upon a well organized and clear cut effort to keep our Auxiliary enlightened as to the political and legislative activities that constantly are being fostered in Springfield and Washington by pressure groups — and Medicine's answer to these paternalistically inspired attempts that can result only in the ultimate destruction of medicine as a free, scientific enterprise, the concomitant inevitable lowering of our national health, because, any type of government control or dictatorship in any and every scientific field irresistably leads to suppression of original research work. You cannot change human nature — the original mold in which man was cast, never has been broken. When that incentive to individual and professional advancement is denied, there first comes irritation, next, angry, hopeful expectancy, and finally, indifferent, helpless resignation!!

Our Women's Auxiliary has a continuous and irrevocable opportunity, both through their individual social activities and their social contacts as a group, to bring to bear and shine upon the laity, the Great White Light of Truth. Truth alone, ever since man first put foot upon this planet has been humanity's sole impregnable citadel in its constant struggle for the freedom and inherent dignity of even the most lowly of all mankind. The laity need us — we in turn must have their good will and help. The Women's Auxiliary is the connecting bond. It is our bounden and most sacred obligation to press on in this endeavor. The women are willing — we must lead the way.

*Editor*: The improved format of the Journal, particularly the type of advertising carried, is a noteworthy improvement. The criterion of scientific papers published has been high. These papers primarily have been directed to the enlightenment of the general practitioner — and we must not forget that it is a general practitioner's Journal. The increased space given to news notes should be encouraged and increased.

The inspiring ideal of collecting personal photographs of individual members of the Society, at no cost to the individual, same being made a part of the Archives of the Society, is of unlimited historical value. More emphasis must be exercised toward this end.

Now just a little gentle spray of DDT — 100 proof. The Editor is in no way responsible for the book reviews — but the book reviews are definitely *mephitic!* We suggest to those compiling these reviews that they give the reader a more general idea of the intrinsic value of the books so that one can determine at once whether he wishes to add that book to his library.

It is our considered opinion that the Illinois State Medical Journal, justifiably merits that high rank it now holds among the scientific periodicals published both in this nation and in other lands.

*Committee on Scientific Work*: This we divide into three parts: First, the commercial exhibits, second, the scientific exhibits, and third, the scientific program.

1. *Commercial exhibits*: These presentations have set a high standard. They are informative, they are not blatant, and that connotes many things, there is no high pressure salesmanship. It appeals to the committee that this type of exhibit is most helpful to the general practitioner. He can investigate and learn about numerous things useful to him in his every day practice. This high measure of excellence should not be deviated from. We were informed that this year the committee directing these displays put into effect specific regulations as to the type of exhibit acceptable. That policy merits our most forceful sustaining.

2. *Scientific exhibits*: The one element in these scientific exhibits that has impressed your committee is that they are basic in appeal. By that we mean they have been prepared, not primarily for the specialists in particular fields, but designed to meet the needs of the

general practitioner who constantly contacts these cases each day in the office and home. The physiological backgrounds have been stressed — in this manner the pathologic symptomatology is clarified; methods of treatment and the necessity for a particular species of treatment in a particular disease becomes apparent to the observer.

We mention a few examples. One has to do with nasal deformities. In this presentation specific emphasis is placed upon the one controlling factor which inevitably results in failure or success, namely, no attempted surgical correction or medical treatment should be initiated or persisted in unless basic physiology of parts involved constantly is adhered to. Bacterial endocarditis is another. Cosmetic surgery, its possibilities, medical, surgical, mental, is another. All these types of patients are common consultants in our offices. The general practitioner sees them first, and information along these avenues aids him immeasurably. They should be encouraged, stressed, and there must be more of them. Your committee is most enthusiastic over this part of the program.

3. *Scientific program*: The program this year has been as alluring as sin, and just as beguilingly attractive. It has been formulated primarily for the general practitioner, and we must ever keep in mind that he is the backbone of this Society. Though men in respective specialities have presented papers, these papers were developed for the information of the general practitioner, and were not the type of papers usually read before specialist societies — said type too often inflicted upon gatherings of general practitioners. For this epoch making advance we give three lusty cheers and an extra loud lion's roar. It is interesting to note at this point that this was the spontaneous and unanimous opinion of your bashful committee, one of whom is an internist, another an orthopedist, and a third one, a urologist. We speculated as to whether this committee was selected to put us on the spot — or perchance, an act of God. However, that is our opinion, and you are stuck with it.

We recommend, and it has been enforced this year for the first time, that all scientific sessions be joint sessions. We adovcate this because of two compelling reasons: (1) Again this is a general practitioner's society and his desires must be paramount; (2) it permits each member to hear every paper he is interested in. *That* is why he attends meetings.

We recommend that all discussions of papers be prohibited. This will insure uniformity of program, it will permit members whose time may be limited to hear more papers within a given period of time, it will add interest to the general meeting as a whole, for as you all know, there is nothing quite as trying, as conductive to personal anguish, as destructive to happy memories of a meeting, as senseless and equally useless, as being compelled — silently — to sit on a hard chair and listen while some one, or two, or three, or four discussants continue to harangue a defenseless and already surfeited audience, repeating ad nauseam the subject matter previously presented by the essayist. We have often speculated whether or not a jury of one's peers, twelve good men and true, would with understanding heart, sympathetic ear, and benignant eye, fondly gaze upon a plea of justifiable homicide, if perchance, and it can happen, one of the audience, goaded at last beyond the limits of human endurance, scourged into mental frenzy, and with the lust for slaughter rampagingly running riot in his brain, rose from his seat of torture, pulled from an innocent fold bag a twelve gauge shot gun, loaded to the muzzle with slugs and ten penny nails, and calmly began taking pot shots at the speaker's rostrum. What do you think?

A prime essential to any successful meeting, be that gathering political, social, economic, scientific, or just an old fashioned "Come-all-ya" is that it begin on time! This is the just due both of the speaker and those who have arrived at that stated hour. To delay is an insult to those who are prompt. This custom, once established and rigidly adhered to, will, above all other factors, lay the foundation and be the cornerstone of every successful meeting.

The patterns confirmed at this year's annual conference should not be deviated from. Wherever and whenever improvement is attainable, that too must diligently be sought after.

And now to our co-workers in the cult of Hippocrates this ends our report.

(Signed)
JOHN P. O'NEIL, Chairman
J. C. REDINGTON
CHARLES PAPIK

DR. O'NEIL: I move the adoption of the report as a whole. (Motion seconded by Dr. Charles Papik, Chicago, and carried).

THE PRESIDENT: The next report will be from the Resolutions Committee, Dr. Frank Deneen presenting the report in the absence of the Chairman, Dr. Mather Pfeiffenberger.

DR. DENEEN: The Resolutions Committee wish to make the following report:

1. *Licensing of Physicians from Unapproved Medical Schools.*

The Committee recommends the approval of this resolution and I so move. (Motion seconded by Dr. D. B. Pond, Chicago, and carried).

2. *Objection to Inclusion of Physicians' Services in the Central Illinois Hospital Service Association.*

The Committee feels that this is too serious a consideration for three men to handle and ask that it be referred to the Council. I so move. (Motion seconded by Dr. J. C. Redington, Galesburg, and carried).

3. *Dissemination of Knowledge Concerning The Hazards of Current Medical Legislation Affecting The Private Practice of Medicine Through The Efforts of The Woman's Auxiliary.*

The Committee recommends its approval and I so move. (Motion seconded by Dr. I. H. Neece, Decatur, and carried).

4. *Change in By-Laws to Eliminate The Name of Professional Demeanor Committee and Substitute The Name Medico-Legal Committee.*

*Whereas,* the present By-Laws in Chapter 9 on page 16, Section 4 on page 17 of our Constitution and By-Laws makes provision for a Professional Demeanor Committee, and

*Whereas,* said name is one which carries with it the need for an explanation, and

*Whereas,* our Society does have need to consider the medico-legal aspect of professional problems, be it therefore

*Resolved,* that the By-Laws in the afforesaid chapter and section be changed to eliminate the name of Professional Demeanor Committee and substitute the name Medico-Legal Committee.

Respectfully submitted,
(Signed)
OSCAR HAWKINSON
DARWIN B. POND
H. KENNETH SCATLIFF

The Committee is under the impression that the name Medico-Legal Committee was dropped for legal reasons, so the Committee recommends that there be no change and that the name remain as Professional Demeanor Committee, and I so move. (Motion seconded by Dr. I. H. Neece, Decatur).

DR. OSCAR HAWKINSON, Chicago: I realize that five or six years ago there might have been reason for making some change. In the pre-caucus meeting last week, this caucus instructed this committee to request a change in our name. It does not mean anything and we have always had to explain it. We were asked to get legal advice which we did. We had our legal advisor in contact and he said definitely there was no reason. The reason which existed five or six years ago did not exist at the present time. I discussed this matter in the Council and was instructed to make a motion that we have a change in name. The legal advisor apparently later changed his opinion and said perhaps we had better not make a change. I am making this explanation so you will understand.

THE PRESIDENT: All in favor of accepting the recommendation of the Committee that no change be made signify by the usual sign. I will call for a rising vote.

(The vote was 29 for a change, 31 voted that the recommendation of the Committee be supported and no change made).

The motion is lost and the resolution is not approved.

DR. DENEEN: These last three resolutions were handed in late after the Committee had met so no action was taken.

5. *Publicity Concerning Sound Selection of Institutions for The Treatment of Cancer.*

*Whereas,* the subject of cancer is at present receiving more publicity in the lay press than ever before as a part of the well-considered effort to reduce its mortality, and

*Whereas,* numerous institutions, such as tumor clinics, are clamoring unwarrantedly for public favor, and

*Whereas,* persons suffering from cancer may be improperly influenced to patronize such institutions, to their own serious detriment.

*Therefore, be it resolved,* that the Illinois State Medical Society urges that fullest possible publicity be given to the following three precautionary criteria on which the sound selection of a clinic or other institution should be based:

1. Clinics or other institutions which advertise their alleged pre-eminence in the diagnosis or treatment of cancer should be avoided.

2. Clinics or other institutions which advertise their records of so-called "cures" of cancer should be avoided.

3. Clinics or other institutions which are not recognized by the American Medical Association, the American College of Surgeons or, in the case of hospitals, the American Hospital Association, should be avoided.

DR. JAMES H. HUTTON, Chicago: Chicago has a Cancer Clinic which makes a good many claims. Some of this publicity has gotten various men connected with it in trouble with the Chicago Medical Society. The Council authorized the Chicago Medical Society to make a survey of the institutions for the care of cancer, with the idea that we might find institutions which would be safe for the public. It was thought that if the House of Delegates would issue a warning to the public, setting forth criteria on which the sound selection of a clinic or other institution should be based, it might be very helpful. This resolution has the support of the Cancer Committee of the Chicago Medical Society.

DR. DENEEN: I move the adoption of this resolution. (Motion seconded and carried).

6. *That The In-coming President be Instructed to Appoint a Committe to Draft a Non-profit, Pre-Medical Plan.* (Introduced by Dr. Harold W. Miller).

*Whereas,* The American Medical Association has approved "Prepayment Medical Plans", and has recommended that the state medical societies organize such plans, and

*Whereas,* State medical societies in thirty-six (36) states have organized, or have in process of organization, non-profit, prepayment medical plans under their own sponsorship and control, and

*Whereas,* the Illinois State Medical Society in 1945, obtained the passage of legislation, providing for the establishment of a non-profit, prepayment medical plan in Illinois under the control of the medical profession, and

*Whereas,* it is desirable to have in readiness a non-profit, prepayment medical plan, meeting the standards adopted by the American Medical Association and similar to those now operating or about to start operations in thirty-six (36) states, therefore

*Be it resolved,* that the in-coming president of the Illinois State Medical Society be instructed to appoint a committee to draft a non-profit, prepayment medical plan which will incorporate the following features:

1. The American Medical Association standards.
2. Which will be in compliance with the legislation obtained by the Illinois State Medical Society.
3. Which will make use of experience already obtained by the State and local medical societies.
4. Controlled by the Illinois State Medical profession.

DR. E. S. HAMILTON, Kankakee: I move that it be referred to the Council. (Motion seconded by Dr. Andy Hall, Mt. Vernon).

DR. HAROLD W. MILLER, Chicago: The reason, gentlemen, for presenting the resolution at this time is solely as a safeguard. You heard the discussion a little while ago on this insurance plan. It is felt that by accepting this resolution it is a safeguard to us that we will not be left without any resource in case the plan fails.

(On a rising vote 52 to 27, the motion to refer the resolution to the Council, was carried).

7. *Approval of The Activities of The National Physicians Committee.*

*Whereas,* the members of the House of Delegates of the Illinois State Medical Society and physicians throughout the State of Illinois recognize the importance and effectiveness of the program of the National Physicians Committee for the Extension of Medical Service during the past six years; and

*Whereas,* the need for substantial expansion of the public relations and educational efforts of the National Physicians Committee is of increasing importance, therefore

*Be it resolved,* that the House of Delegates of the Illinois State Medical Society re-affirm their confidence and approval of the National Physicians Committee activities and recommend to its constituent societies and individual physicians of Illinois that they give the greatest possible financial and moral support to the National Physicians Committee.

DR. DENEEN: In the absence of the Committee's report I recommend the adoption of the resolution. (Motion seconded by Dr. R. H. Hayes, Chicago, and carried).

THE PRESIDENT: We now come to unfinished business.

DR. CHARLES H. LESAGE, Dixon: I would like to ask concerning action on dues for men in the Veterans' Administration with Army commissions.

THE PRESIDENT: These men to whom you refer have not been members of this Society.

DR. LESAGE: Some are members. We are also taking in new members and we do not know how to classify them. We do not want to make any recommendations but we would like an opinion.

DR. R. H. HAYES, Chicago: Are they licensed to practice?

DR. LESAGE: Yes.

DR. HAYES: Then they should pay dues.

DR. D. B. POND, Chicago: I move this be referred to the Council. (Motion seconded by Dr. R. H. Hayes, Chicago, and carried).

DR. E. S. HAMILTON, Kankakee: As a result of the action which the House took, not only your Committee but also some members of the House are in doubt about all the amendments to the original motion because they were given extemporaneously and not in written form. If the Committee is to be elected for next year and if it is possible for it to get a report ready, it would be impossible for it to proceed without further instructions. I make a motion that the Committee for the Study of Prepayment Plans work on instructions of and report to the Council of the Illinois State Medical Society until the next meeting of the House of Delegates. (Motion seconded by Dr. James H. Hutton, Chicago).

DR. H. K. SCATLIFF, Chicago: I believe that if we do this directly under the Council that many of the delegates, the representatives of the physicians throughout the state, will not have an opportunity to voice their opinion. Representatives of the Council in the past have had a different view of this. Many of the men are practitioners of medicine. I believe it would be well to have some control over the Council.

DR. R. K. PACKARD, Chicago: Do I understand by your motion that the Council can institute a prepayment plan and put it into being? I have no objection to this Committee's working on it. I have no objection at all that they study it for two or three months and if they feel that the House of Delegates should have a special meeting to reconsider this, that they ask that such be called. The House should take action. I think the Committee was originally appointed to work through the Council and then report back to the House of Delegates. I question the advisability of waiting a year.

DR. HAMILTON: That is exactly what I was trying to avoid by this motion, the loss of another year's time. If we are to accomplish anything and if it has not been completely emasculated, if we are to accomplish anything in putting in a plan we must work under some instructions. The instructions were so indefinite that I do believe that if Dr. Packard could get up and state them, it would clarify the matter. If we are going to get anywhere with the plan the Committee must refer to some one and since there will not be another meeting of the House for a year, there should be someone to whom the Committee can report.

DR. PACKARD: I believe this Committee should continue its work. I think they should make a very serious attempt to work out the recommendation that has been made by this House of Delegates. If after a very serious attempt to carry out the instructions of the House of Delegates, they work out something new that they think should come to the House of Delegates, they should ask for a special meeting of the House of Delegates to consider it. After all, the House of Delegates is the governing body. I amend the motion to that effect. (Amendment seconded by Dr. H. K. Scatliff, Chicago).

They should continue the work and any time they have a recommendation to make that a special meeting of the House of Delegates should be called.

DR. HAMILTON: The original motion made by Dr. Packard in 1944 was that the House of Delegates approve the plan in principle and the Council appoint the committee to make the study and that this committee report to the Council as soon as feasible; in other words, the responsibility was given to the Council to appoint the committee. Then there was some discussion about it. A little later Dr. Packard made the recommendation that the committee be appointed by the Chairman of the Council. He further agreed to the inclusion of other insurance plans other than the Blue Cross Plan. Finally he accepted the recommendation and the thing was all to be handled by the Council. That is from the records.

DR. PACKARD: I am not going to question the records. The thing I am interested in is that this resolution has appeared in three different forms in the Journal since it appeared. I would like the original motion.

DR. SCATLIFF: The point is that the Committee has presented to us the endorsed principles of prepayment medical care which they desire to have approved. They have approved one insurance company. We approve the principles of prepayment insurance but do not want to confine it to one policy or one company.

DR. HAMILTON: It has been stated repeatedly that other companies can write it and other companies have had the opportunity. We have not signed up with any one only and that is a gross misstatement of fact.

DR. PACKARD: I want to apologize to Dr. Hamilton. I have no record that this was to be presented to the House of Delegates. However, I do wish to remind you that the committe appointed — and I am quite sure it was consensus of all of us to report to the House of Delegates — the committee themselves said it was of sufficient importance and that it should be presented to the House of Delegates before final action was taken. Last January a special meeting of th House of Delegates was called for that specific purpose.

DR. HAMILTON: What did the House do?

THE PRESIDENT: They approved the report of the Committee.

DR. D. B. POND, Chicago: Most of you remember in that January meeting to consider this plan that we got all tired out and we voted on it. Some of the men did not know what they voted on. I personally feel that this is important enough to come before the House of Delegates and that we should have a special meeting of the House of Delegates to consider this plan after the Council has mulled it over, and after those changes have been attempted to be made. You do not know whether we can make them all. You are going to ask this insurance company to make some changes and may be they will and may be they will not. When the plan is ready it should come before this body.

DR. PACKARD: I moved that a special meeting of the House of Delegates should be called just as soon as this is ready because speed is necessary. One member said if it has to be on the 4th of July let us have it.

DR. L. O. FRECH, Decatur: As I understand the Council cannot change anything done here. The amendments were voted to be added to the Committee's report. The data that is in the amendment must be included in the Committee's report on the policy or there is no prepayment insurance.

THE PRESIDENT: That is as I understand.

DR. HAMILTON: There will be no prepayment plan in Illinois unless the Committee is given some latitude. I sometimes wonder if that is what is wanted. It is a waste of time for the Committee to work further if they have no intention of following their recommendations. We are asking for instructions as to what you want your Committe to do. If you do not want us to do anything that is what the acceptance of Dr. Packard's amendment is going to mean.

DR. A. H. BITTER, Quincy: As most of you recall, when we had our special meeting in January, it was called at nine o'clock. We came uninformed in regard to what the committee was going to do. Four or five of the twelve members of the Committee were able to read papers. By that time it was nearly noon and they began to hand out the reports of the others. We were handed reams of paper on this report and we were supposed to give an intelligent answer as to what we wanted. I was unable to get an intelligent conception of just what this entire plan was. I was voting without probably being fair to myself or the county I represent. I think today we have a little better understanding in regard to this program. There is still confusion in the minds of most of us. I made a motion at the last meeting of the House of Delegates that if we were going to have faith in the Committee all that was necessary was to give them a vote of confidence. I still feel that way. These men have spent hours of work trying to understand this insurance plan so as to be able to make a decision. Although I agree with Dr. Packard in his remarks on most of the things, I think this Committee should be given the privilege of reporting to the responsible body which is the Council instead of bringing back the delegates who will not understand more at a second meeting than at the first. I heartily agree with Dr. Hamilton that this committee should report to the responsible body in our Society which is the Council and let their decision stand.

THE PRESIDENT: Are you ready to vote on the amendment?

DR. PACKARD: The House of Delegates has approved the amendments as offered. Ultimately this thing goes back to the Committee to report back to the Council. I will withdraw my motion that a special meeting of the House of Delegates be held. If the Council does not see fit and the Committee does not see fit to call a special meeting of the House, it is up

to their judgment. I will withdraw my amendment with the consent of the second. (Dr. Skatliff consented).

THE PRESIDENT: The vote will be on the original motion. Dr. Hamilton will you please restate your motion.

DR. HAMILTON: That the activities of the Committee for the study of prepayment plans be under the direct control of and that they report to the Council for instructions until there is another meeting of the House of Delegates. (Motion carried).

THE PRESIDENT: We now come to unfinished business. There are several things which must be acted upon.

THE SECRETARY: I have a recommendation from the Veterans Service Committee asking that this Society develop an endowment for the purpose of assisting in the education of the sons and daughters of former medical officers who were killed in service. They have a very definite plan. This was presented to the Council. In view of the fact that it would necessitate changes in the by-laws for the creation of another endowment which would be handled separately from all the other funds, the Council automatically referred it to the House of Delegates. If the House of Delegates wishes to re-refer it to the Council for recommendation at the next annual meeting that probably would be a wise thing.

DR. CHARLES ROTH, Chicago: I so move. (Motion seconded by Dr. Robert H. Hayes, Chicago, and carried).

THE SECRETARY: I have the following communication from Dr. George F. Lull:

The Committee on National Emergency Medical Service of the American Medical Association, which was appointed in accordance with recommendations of the Board of Trustees adopted by the House of Delegates at its meeting held in December, 1945, has requested the Board of Trustees to give them permission to suggest that each constituent state medical association appoint a similar committee. This request has been approved by the Board. The recommendation adopted by the House of Delegates is as follows:

The Board of Trustees would recommend to the House of Delegates that it authorize the Board of Trustees of the American Medical Association to appoint a committee of seven to be known as the Committee on Military Service. This committee shall include four civilian physicians who served in the war and three others. The committee will study the many communications that have been received and the suggestions made by physicians in the armed forces. The committee will also formulate policies for recommendations to be forwarded through the Surgeons General to the Secretary of War and the Secretary of Navy expressing the views of the medical profession in planning for proper utilization of the services of physicians in any national emergency.

The Chairman of the Committee, Dr. Edward L. Bortz of Philadelphia, desires that as much publicity as possible be given the formation of these committees.

DR. FRANK P. HAMMOND, Chicago: I move we approve the recommendation and that such a committee be appointed. (Motion seconded by Dr. Robert H. Hayes, Chicago, and carried).

THE SECRETARY: I have had several letters relative to a new Army Medical Library building. It has come before the House of Delegates for the last ten years. It has been approved on several occasions in recent years by the American Medical Association.

DR. G. C. OTRICH, Belleville: I move that it be endorsed.

(Motion seconded by Dr. Harlan English, Danville, and carried).

THE SECRETARY: I have a letter from the Allegheny County Medical Society asking that the American Medical Association provide at some central point such as Chicago or Washington, D.C., a briefing course of three or four days for indoctrination and presentation of factual information as well as any other information which may be useful for speakers who meet the public, particularly the Executive secretaries of State and County Medical Societies, so that after three or four days of such training these full-time men who have been exposed to at least the nucleus of preparation will be in a better position to transmit authentic information to the public. It is taken for granted that the traveling expenses of each of these participants will be paid by the corresponding societies.

DR. I. S. TROSTLER, Chicago: I move that it be approved. (Motion seconded by Dr. F. M. Hagens, Lincoln, and carried).

THE PRESIDENT: The next order of business is the election of emeritus members.

THE SECRETARY: I have the following list of applicants for emeritus membership. They have all been made emeritus members by their component societies and are properly qualified.

*Chicago Medical Society*:

Dr. Albert R. Martin, 3138 Sheridan Road, Chicago
Dr. Abraham W. Schram, 5439 East View Park, Chicago
Dr. I. B. Diamond, 30 N. Michigan Avenue, Chicago
Dr. S. E. Donlan, 3065 Palmer Square, Chicago
Dr. John J. Gill, 2210 E. 69th Street, Chicago
Dr. David Lieberthal, 515 W. Barry Avenue, Chicago
Dr. G. W. Mahoney, 4215 Sheridan Road, Chicago
Dr. Nels C. Meling, 1611 Chicago Avenue, Evanston.

*Kane County*:

Dr. George Schneider, Elgin
Dr. George W. Hahn, Aurora
Dr. A. W. Moore, Aurora
Dr. H. B. Carriel, Elgin

*Winnebago County*:

Dr. R. C. Bourland, Rockford

*Tazewell County*:

Dr. H. W. Walker, Pekin

*Montgomery County*:

Dr. H. A. Seymour, Hillsboro

In regard to Dr. Seymour, he has been a member of the Society for more than thirty-five years and has paid dues for more than thirty-five years, but not consecutively. I would like to recommend that this list of men be made emeritus members.

DR. F. O. FREDRICKSON, Chicago: I so move. (Motion seconded by Dr. R. H. Hayes, Chicago, and carried).

THE SECRETARY: I would like the usual motion to thank everybody who has given time and effort to make this meeting successful. I want to call attention to one man who has done an outstanding piece of work, Dr. John A. Mart. Both he and Mrs. Mart have been working for many weeks on this meeting.

DR. F. O. FREDRICKSON, Chicago: I so move. (Motion seconded by Dr. J. J. Moore, Chicago, and carried).

THE PRESIDENT: Is there other new business?

DR. HARLAN ENGLISH, Danville: Our Committee on Rural Medical Care has met with representatives of 140,000 farm units. I will read you a quotation from our report.

DR. H. K. SCATLIFF, Chicago: I would like to urge upon this House of Delegates a recognition of their responsibility for the quality of physicians to serve the state in the future. The present scheme of taking premedical students for service will lead to inferior physicians. I move that this body go on record as recommending the discontinuance of drafting of premedical students and that premedical students already taken be placed on an inactive status. (Motion seconded by Dr. Andy Hall, Mt. Vernon, and carried)

DR. SCATLIFF: I further move that a copy of this motion be sent to the President of the United States, the Director of Selective Service, and our own Committee in the American Medical Association on Medical Education. (Motion seconded by Dr. Andy Hall, Mt. Vernon, and carried).

THE PRESIDENT: It has been customary to remit the dues of members in service.

DR. R. H. HAYES, Chicago: I so move. (Motion seconded by Dr. H. W. Miller, Chicago, and carried).

DR. H. K. SCATLIFF: Can we recommend a change in the name of the Committee on Professional Misdeamnor?

THE PRESIDENT: That will require a change in the by-laws.

DR. SCATLIFF: Having heard the remarks of the gentlemen who are on the Committee and knowing the quality of the work they have done, and the fact that some of this work involved medico-legal questions that are not court matters, I believe we should take their wishes into consideration that they have evinced a desire that the name of the Committee be changed to Medico-Legal Committee. I move that the by-laws be revised to include this. (Motion seconded by Dr. Oscar Hawinkson, Chicago, and carried).

THE PRESIDENT: This will have to lay over until next year.

THE SECRETARY: I have the report of the Committee on Awards for Scientific Exhibits:

*GROUP I. ILLUSTRATING ORIGINAL WORK.*

*Silver Medal*: Walter S. Priest, Jacques Smith, Charles J. McGee and Eugene Hildebrand: Antibiotic Therapy of Subacute Bacterial Endocarditis.

*Bronze Medal*: Robert H. Herbst, James W. Merricks: Transurethral Drainage of Seminal Vesicles: Catheterization and Dilatation of the Ejaculatory Ducts.

*Certificate of Merit*: Hilger P. Jenkins, Rudolph Janda, James Clark, Edward Fenz and Howard Owens: Gelatin Sponge — Studies on Absorption and Hemostatic Action.

*Certificate of Merit*: A. A. Mertz: Fractures of the Hip.

*Certificate of Merit*: M. Herbert Barker: Infectious Hepatitis.

*GROUP II. EXHIBITS OF EXCEPTIONAL EDUCATIONAL VALUE.*

*Silver Medal*: Frederick H. Falls and Charlotte S. Holt: Puerperal Sepsis.

*Bronze Medal*: Carroll L. Birch and Louis B. Limarzi: Hematology.

*Certificate of Merit*: Paul H. Holinger, Edwin F. Hirsch and Albert H. Andrews, Jr.: Bronchogenic Carcinoma.

*Certificate of Merit*: Leon Unger and Isabelle Brandt: Allergic Conditions — Diagnosis and Treatment.

*Certificate of Merit*: Irving Treiger: Correlative Study of Cardiac Diseases.

THE PRESIDENT: It now becomes my very pleasant duty to introduce our president-elect. Two years ago when he gave me this gavel and inducted me in office, I thought one year later I would perform a similar service for him. It has been two years. These years have been very pleasant and they have been rather arduous. They have taken quite a lot of effort and a sense of responsibility. During this period of time I have tried to do one thing; I have tried to make as many friends among other groups of the medical profession as I could. What has been accomplished it is impossible to state. I have tried at every opportunity to make friends. I know your new President will carry on to a much greater degree and he will make greater contacts. It is a great pleasure to induct into office Dr. Robert S. Berghoff.

DR. BERGHOFF: Mr. Retiring President and Members of the House: I certainly shall not take much time for my brief acceptance speech. I want to say a word or two to my friend, the retiring President, Dr. Coleman. We get so few opportunities as we go through life to tell a man how much we appreciate his qualifications. He knows as I have told him once or twice in the last two years, that I know him to be very humble, very earnest and very intelligent. He is full of dynamite, he is tireless.

I want to talk seriously to the House for three or four minutes. I do not have to tell you that I appreciate the honor and the high privilege and the great responsibility of acting not only as president of almost 10,000 doctors and being their spokesman for the coming year. The mere fact that it is five minutes to two at the end of our meeting, one hour and a half late, shows how complex our problems are.

It is not that we are faced with one big issue for the coming year but that there are so many important things that will face the Society. I accept this position with great confidence. I know I will have your support. The foremost problem that faces us is the socialization of medicine. We have talked about that a great deal this morning. That to me is class legislation. The medical profession has overcome terrific obstacles in the past and we shall do it again. I feel that we in Illinois, ten thousand strong, are but a cross section of the more than 100,000 doctors in the country. I believe as a class we are united in one big issue. It has been my pleasure and privilege in the last fifteen or sixteen years to have gone to 61 of our 102 counties to preach the gospel of heart disease. I have enjoyed it and I have met so many of you. I trust this year to go to the remaining 40 counties to carry not the gospel of heart disease but to battle every issue that is not for the best interest of the medical profession. I am not fearful as I accept this rather enormous job. I am humble. I tell you in all confidence if you give me what you have given all your presidents, I am looking forward to this very keenly. The battle is on and I am willing to fight for you all with all my power.

On motion duly made and seconded, the House adjourned *sine die* at 2 P.M.

## REDUCE SURGICAL RISK FOR INFANTS WITH BLOCKED STOMACH OPENING

Operative risks for infants, suffering from a tumor obstruction at the opening of the stomach, are fast declining, according to three physicians from the Harvard Medical School, Boston.

The doctors, writing in the June 22 issue of *The Journal of the American Medical Association,* are: William E. Ladd, professor of child surgery, emeritus, Harvard Medical School, and surgeon-in-chief, emeritus, the Children's Hospital, Paul F. Ware, assistant in surgery at the Harvard Medical School, and resident surgeon at the Children's Hospital and Lawrence K. Pickett, formerly surgical intern, the Children's Hospital.

The article states that 1,145 patients with this condition, known as pyloric stenosis, have been operated on by various members of the Surgical Service of the Children's Hospital since 1915 with a death rate of 40. "In the past three and one-half years 225 consecutive cases of pyloric stenosis have been treated surgically without a fatality."

Pyloric stenosis predominates in males. The physicians state that "approximately 85 per cent of the cases occurred in male infants" in their hospital. The condition occurs most frequently in the first born of a family, averaging 50 to 60 per cent of cases in most series. "Our own figures bear this out," they state, "as our patients represented first births in approximately 55 per cent of cases." Heredity is another predisposing factor. "Families with the disease present in several siblings or found in successive generations are not infrequent."

The symptoms which usually appear from the second to the fourth week are reduction of water in the tissues, vomiting after each feeding and loss of weight. Also, the tumor can usually be felt as a firm, hard, freely movable body, to the right of the naval and a little above it. Diagnosis should be made as soon as possible with x-rays. Persistent vomiting should be immediately investigated for if the condition continues without relief by surgery, death soon will ensue.

The authors conclude that the operation, done promptly by a skilled, experienced surgeon, preceded and followed by proper management, will result in cure in almost everyone.

# The 1946 ANNUAL MEETING IN PICTURES

**The first post-war meeting was held in the Palmer House, Chicago, May 14, 15, 16. If you did not attend, this pictorial report will show you something of what went on, who was there, and perhaps induce your own attendance next year.**




Registration desk (Left) was a busy spot throughout the three days. Here more than 3,200 physicians and their wives filled out cards, bought luncheon tickets, met friends. Registrations from Lima Peru, Amsterdam Holland, Paris France, and Geneva Switzerland gave the meeting an international touch. In addition, 407 exhibitors filled out cards. Pleasing to everyone was the fact that many present were just out of service, or on terminal leave.





A popular spot (Above) was the Coke Bar, where three men were kept busy opening the icy bottles served with the compliments of the makers. The weather was warm but not hot, and for once the convention-goers did not have to dodge rain drops. (Left) The crowd swarms out of the grand ballroom into the exhibit hall at the conclusion of one of the general sessions. A change from the program of a few years past was having most papers read in general sessions instead of section meetings. Only section meetings were those for Radiology, and Eye, Ear Nose and Throat. If you have a preference for general sessions, or for section meetings, your Secretary will be glad to hear from you.







(Above) The speaker's table at the
gathered in the grand ballroom. Left
told of his experiences as a foreign
Harrison H. Shoulders, now President
Berghoff, President, Everett P. Colema
Chairman of the Council. The camera
Medical Association and Edwin S. Hamil

One of the liveliest luncheons of the meeting was that held by the 50 Year Club. Forty-two members were present but the room was also crowded with friends seeking old acquaintances. Samuel C. Stanton, C. S. Bacon and Andy Hall, chairman of the club, are probably planning next year's shindig.





Seven members were elected to t
Delegates (elsewhere in this issue)
O. Lane, Harlan English, Harry M.
Leo P. A. Sweeney, and Wade C.
representation on the Council by th



The Loyola Medical Alumni luncheon was another large gathering. At the speaker's table, left to right, Rev. G. G. Grant, S.J., Alumni Secretary, Robert E. Lee, Secretary, Italo F. Volini, Robert S. Berghoff, Very Rev. James T. Hussey, S.J., President of Loyola University, Herbert E. Schmitz, President, Loyola Medical Alumni, Francis J. Gerty, Stuart C. Thompson, Ass't Dean, Edward A. Piszczek, and George A. Hellmuth.







er looked like this when the large crowd
R. L. Sanders, Mr. William McGovern, who
nt, George Lull, Secretary of the A.M.A.,
A., Harold M. Camp, Secretary, Robert S.
President, and Percy E. Hopkins, retiring
T. C. Routley, Secretary of the Canadian
ple in the foreground.



Three past-presidents of the Society (facing the camera) are enjoyin
the annual dinner. Left to right they are Mather Pfeiffenberger, F. C
Fredrickson, and E. H. Ochsner. Mrs. Ochsner is seated between the las
two. Dr. Ochsner served the Society in 1924. None of the previou
presidents are living.



the second session of the House of
ft to right, Charles H. Hulick, Charles
w, left to right, H. Prather Saunders,
increased Chicago Medical Society's



Eighteen members attended the Maternal Welfare Committee's luncheo
The photographer identified Fredrick H. Falls, Alfred B. Owen, T. B. W
liamson, E. H. Weld, C. H. Hulick, Henrietta Herbolsheimer, L. O. Fre
and Gilbert H. Edwards. The American Women's Medical Association w
held a breakfast, and the University of Illinois Medical Alumni Associatio
who had a luncheon, were among other groups who meet during t
sessions.



"The best yet!" That was the common opinion of the Scientific Exhibits. Beautifully displayed and well lighted, they were assembled under the direction of John A. Mart. (Right) Leon Unger explains his own exhibit on allergic conditions to Harry Olin. (Below) Leo Hardt has an intensely interested audience as he goes over details of his display.







R. L. Sanders of Memphis delivers his Oration in Surgery, *"The Gall Bladder and Duct Problem."* Dr. Sanders is an effective speaker.



Technical exhibitors praised the crowds, found many an interested listener as they told of new products. (Left) M. R. Weissbuch, at the right in the picture, has evidently learned something pleasing from one of the exhibitors. (Right) At another booth, three members discuss problems. Second from the left, Henry Falk, then Rollo K. Packard, and at the right, Oscar W. Hawkinson.






# Original Articles

## THE GALLBLADDER AND DUCT PROBLEM

By
R. L. Sanders, M.D.,
MEMPHIS, TENNESSEE

Collective experience has demonstrated the fallacy of many of our former beliefs regarding the surgical treatment of gallbladder and duct disease, yet several phases of this problem are still in a debatable stage. One of the major controversial points concerns the indications for cholecystectomy. Investigations of surgical results, aside from mortality, reveal that approximately 10 per cent of patients are only partially relieved and 5 per cent are unimproved or made worse by removal of the gallbladder. Considering the various pathologic types of cholecystitis and the many pitfalls in diagnosis, even with all the technical facilities at our command, it is not surprising that surgical judgment occasionally errs in the decision as to whether or not operation is indicated. Especially is this true of chronic non-calculous cholecystitis, wherein most of our surgical failures are found. Many errors, however, may be avoided by observance of more rigid criteria in the selection of patients for operation, and this, in turn, is made possible by more penetrating inquiries into the patients' complaints and more exhaustive examinations.

Patients with gallbladder disease may be classified into three types: (1) Those who have digestive symptoms but no colic; (2) those who have colic but no digestive symptoms; and (3) those who have both colic and digestive symptoms.

In studying patients in the first group, our problem is to determine whether the symptoms are in reality related to gallbladder disease or to some other disturbance. It should be borne in mind that the postprandial epigastric distress, ache or pain, the eructations of gas and sour material. the abdominal distention, the nausea and vomiting, constipation and diarrhea which characterize cholecystitis are also associated with a number of other abnormalities. One may likewise be called upon to evaluate such vague manifestations as exhaustion, insomnia, dizziness, spots before the eyes, pains and aches in and about the muscles and joints, headache, a capricious appetite and a bad taste in the mouth, all of which are common to toxic conditions of various origin. Again, the patient may describe symptoms resembling those of duodenal ulcer in character, time of onset, and even periodicity. If, as occasionally happens, a duodenal ulcer is also present, a proper classification may be practically impossible.

Especially is confusion likely to arise in the differentiation from appendicitis. Right iliac pain is not uncommon in cholecystitis and, conversely, a high lying inflammatory appendix may be mistaken for an infected gallbladder. Such cases call for a fine interpretation of all the symptoms and signs and use of all the diagnostic measures at our disposal.

Upper abdominal colic is a symptom of approximately one-third of patients who have

Presented as Oration in Surgery, 106th Annual Meeting of the Illinois State Medical Society, Chicago, May 15, 1946.

cholecystitis without stones, the causative agent being pericholecystitis, spasm of the gallbladder and ducts and of the sphincter of Oddi, or some type of mechanical obstruction outside the duct. When combined with other evidence of cholecystitis, one may assume that this symptom substantiates the diagnosis. Colic alone, however, may indicate disturbed liver function, disease of the pancreas, a gastrointestinal infection or a heart lesion.

A considerable number of patients, particularly those of advanced age, have heart disease in addition to the gallbladder disturbance, with practically identical symptoms. In such cases, one may question the advisability of surgery. The risk being small, we see no reason for withholding operation. On the contrary, we have found reason to believe that heart complaints are at times alleviated by removal of a diseased gallbladder. Our opinion is based upon observation alone. In view of the similarity of the symptoms of disease of the two organs, it may be that the symptomatic improvement does not arise from any beneficial effect upon the heart; rather, one may have been mistaken in assigning to the heart symptoms which were in reality of cholecystic origin. This point can only be decided by comparisons of preoperative and postoperative electrocardiograms.

Some light may be thrown on the various diagnostic problems encountered in gallbladder disease by gastric analyses and duodenal drainage. The latter is most valuable as a means of studying the concentration and emptying function of the gallbladder. More important, however, is the roentgenographic study. The demonstration of poor function in a patient who presents the symptoms of cholecystitis is ample indication for surgical interference. Poor function alone may be of nervous or other origin and thus is not sufficient reason for operation.

Regardless of the roentgenographic picture, when the symptoms of cholecystitis are *clear cut, severe* and *persistent,* we have no hesitancy in advising operation. The roentgenogram is not always a dependable means of determining the true pathologic condition. In some of our well established cases of cholecystitis, including those with stones, the roentgenogram has failed to show either stones or any alteration of function. Our experience in this respect does not coincide with that of a number of other surgeons, who report having observed positive roentgenographic evidence of gallbladder disease with stones in 95 per cent or more of their cases.

We believe, also, that in the presence of associated pathologic changes in other organs, particularly the liver and pancreas, surgery is to be seriously considered, even though the roentgenograms are negative. The gallbladder does not tend toward spontaneous recovery, and whatever the primary site of the infection, it serves to maintain the inflammatory process in the whole.

There is no question as to the necessity for operation when the roentgenogram demonstrates stones. The vast majority of these patients give a history of colic and many of them report having had some degree of jaundice. Although the symptoms may be mild and the function of the gallbladder appears little altered or not at all, it is the better part of wisdom to rid the patient of this source of trouble. Too many of these gallbladders containing "silent stones" erupt unexpectedly into an acute catastrophe.

Another possibility to be considered is that of malignancy. The percentage of carcinomas of the gallbladder and ducts is small, yet it is significant that stones are found in almost every case.

A study of our cases from the pathologic standpoint in an effort to determine which type of chronic cholecystitis is most amenable to relief by surgery revealed that removal of the thick walled gallbladder with stones and associated cholesterosis (the "strawberry" gallbladder) practically always affords complete relief, provided the liver and other organs have not been too severely damaged. The next best results have been obtained following cholecystectomy for simple cholecystitis with stones, and finally, following removal of the non-calculous gallbladder with extensive inflammatory reaction and cholesterosis or papillomas.

Once the indications are established, the sooner operation is performed the better. Cholecystitis is a recurrent and progressive disease, and many surgical deaths are in reality medical deaths, from lack of surgical treatment until the adjacent organs have become hopelessly involved in the pathologic process. Statistics show that the mortality increases commensurately with the

duration of the gallbladder symptoms. Operations upon the common duct, frequently necessitated by long-standing cholecystitis, further increase the hazard.

One of the strongest arguments in favor of early operation lies in the danger of an acute attack. In the majority of cases, acute attacks are preceded by a long-standing chronic infection and are induced by obstruction of the cystic duct by a stone, though they may be provoked by edema or strangulation of the ducts from some other cause. The chief danger is in perforation, which carries a high mortality.

The question of the most opportune time for operation in acute cholecystitis, no less than in certain of the chronic forms of the disease, may test one's surgical judgment to the utmost. Here, again, the difficulty is that the symptoms do not always reflect the true pathologic condition.

The clinical signs which we interpret as demanding immediate surgery are (1) sustained abdominal pain, (2) a tender mass in the right upper quadrant; (3) abdominal rigidity, (4) an elevation of temperature and (5) a rising leukocyte count. Especially do we regard sustained pain and a tender mass as positive indications. Early in the attack, a mass may not be palpable, rigidity and tenderness may not be pronounced, and the temperature, pulse and leukocyte count may be essentially normal. In these cases, one may delay operation while measures are taken to restore the depleted fluid balance in the tissues and otherwise prepare the patient. If the patient is in good condition, preparation over a period of 12 to 24 hours is sufficient. Often, however, a more extensive preparation is desirable, especially if the patient presents a poor risk. Fortunately for these, the attack will usually subside, permitting operation at a more advantageous time. One can generally determine what course the acute process is going to take within 24 to 36 hours after the onset. If, during this period, the symptoms do not begin to subside or if they become aggravated, operation should be undertaken without further delay. Although the clinical picture is not always consistent with the pathologic process, a close watch of the patient and proper laboratory studies should enable one to determine when this point is reached.

One factor in the high mortality of acute cholecystitis is delay in hospitalization of these patients. The death rate increases in direct ratio to the interval between the onset of symptoms and the patient's admission to the hospital. By immediate hospitalization, the patient can be better assured of having the care suited to his particular needs and thus can be promised a more favorable prognosis.

A second vital influence upon the successful outcome of gallbladder surgery is the preoperative and postoperative care. In studying the causes of death from cholecystectomy, one finds that cardiac and respiratory complications predominate, that failure of liver and kidney function is responsible in a smaller number, and that bile peritonitis and other complications are responsible in a few. Many of these deaths might be prevented by proper studies and corrective treatment, both before and after operation, of associated organic or systemic disorders. We are also finding that early ambulation following operation may go far toward minimizing the incidence of circulatory and respiratory complications.

During the past few years, we have employed spinal anesthesia almost exclusively in our operations upon the biliary tree, having found that it adds materially to the safety of the procedure. Not only does this method offer better protection against pneumonia and a more comfortable postanesthetic course, but it also provides better relaxation and thus facilitates the surgical performance.

One of the most important factors for the safety of the patient, and certainly the greatest aid to the surgeon is ample exposure of the operative field. In the majority of cases, an upper right rectus incision, its middle over the common duct, is suitable. It is our custom, however, to employ the supraumbilical transverse incision in most obese patients. The tissues of these individuals are usually friable, and this approach provides a safeguard against wound disruption and hernia.

Insofar as the type of operation is concerned, cholecystectomy is recognized as the procedure of choice, in that recovery is rapid, the mortality

is low, and the necessity for further surgery obviated. The risk of a primary cholecystectomy, moreover, is far less than that of a secondary operation. Nevertheless, one's chief concern should be the safety of the patient. If the patient's condition is poor, or if the inflammatory process is so extensive that identification of the ducts and vessels is impossible, one should not hesitate to compromise with cholecystostomy. Drainage of the gallbladder may be a life-saving measure, especially following exploration of the ducts. The gallbladder may then be removed at a more advantageous time. We usually advise a subsequent cholecystectomy, as definitive surgery offers the best protection against liver damage.

If the inflammatory process is severe, the technic of cholecystectomy may present some difficulties. Dissection should be carried out in a dry field, and one should be sufficiently familiar with the minute structures to avoid their injury. The ducts and vessels are often abnormally situated, either naturally or because of edema of the tissues or displacement by adhesions, and accessory ducts are commonly encountered. Incision or ligation of these anomalous or displaced structures may lead to grave consequences. No doubt, many so called "liver deaths" are the result of damage to the blood vessels during removal of the gallbladder, and duct strictures incident to surgical trauma are found in a conspicuous number of operations upon the biliary tree.

It is our custom to isolate the cystic duct and determine its relation to the common and hepatic ducts, then ligate the cystic duct and artery and proceed with removal of the gallbladder. In chronic or elective cases, the dissection is begun at the cystic duct and continued from below upward, whereas if the condition is acute and the gallbladder greatly distended, dissection is begun at the fundus and carried downward. When jaundice is present, however, exploration is first carried out to determine the cause of the obstruction. Should an acute pancreatitis or a malignancy be found, it may be necessary to conserve the gallbladder. In these cases, the gallbladder is usually not materially diseased and may be successfully utilized for anastomosis to the intestinal tract.

Whether to drain or not to drain the abdominal cavity following cholecystectomy is largely determined by individual experience. Extensive infection, of course, calls for drainage. Otherwise, the question is more or less contingent upon the finding of accessory bile ducts, and whether or not the operative field can be made perfectly dry. Formerly, we usually closed the abdomen tight and our results were excellent. Now, we are inserting simple Penrose drains in almost every case, as a precautionary measure. The drains are brought out through a stab wound and removed after four or five days.

The second question which commands most of our attention in this dual problem of gallbladder and duct disease concerns the indications for opening the common duct. Although obstructions necessitating choledochotomy may arise from stricture, carcinoma of the duct or pancreas, pancreatitis or other abnormalities, the vast majority are produced by a stone, and it is in this group that we are particularly interested.

Unquestionably, surgeons everywhere are openly exploring the ducts in an increasing number of cases. One reason for this is the fact that more patients are being operated upon for cholelithiasis and fewer for non-calculous cholecystitis. Another is that the duct may contain stones, even though the gallbladder contains none, and still another, the possibility of reformation of stones in the duct subsequent to cholecystectomy alone. These are valid reasons. We believe, however, that the ducts should be opened only in the presence of definite indications, which, in our opinion, are the following:

1. Palpation of a stone. This is not always an easy matter. Further, one should take care not to mistake an enlarged gland for a stone in the duct.

2. Abnormal dilatation of the duct. Again, one should first be sure that the dilatation is not functional, in compensation for loss of gallbladder function, or that it is not due to extrinsic mechanical obstruction. Or, it may be secondary to a gallbladder infection and, in this event, amenable to relief by cholecystectomy alone. If there is evidence of thickening of the duct walls and infection within, however, choledochotomy is advisable; even though a stone should not be found, drainage should be instituted in order to relieve the disease condition.

3. A contracted gallbladder. When one encounters a gallbladder no larger than the thumb,

one may be sure of a long-standing infection. The gallbladder may not contain stones, yet it is more than likely that they will be found to have migrated into the common duct.

4. Multiple stones in the gallbladder with an enlarged, patent cystic duct. Frequently, stones too small to be detected by the palpating hand will pass through a patent cystic duct into the common duct. This may happen during mere manipulation of the gallbladder. In such cases, it is not only advisable to open the common duct, but the gallbladder should be removed first in order that one may be sure the duct is entirely free of stones at the conclusion of the operation.

5. Jaundice or a history of jaundice, especially if associated with chills and fever or with gallstone colic. Since these symptoms are often produced by other disturbances than a stone, a thorough search should be made for an obstructing lesion before the duct is opened. It should also be borne in mind that jaundice is not always associated with duct stones. In only about 50 per cent of our cases in which duct stones were found was there jaundice or a history of jaundice.

6. Flocculent bile in the duct. When the presence of a stone seems doubtful, a small quantity of the contents of the common duct should be aspirated. If the bile is cloudy and flocculent, the duct should be explored and drained. Not infrequently, an obstructing stone will be found at the lower end.

To preclude a second choledochotomy, every possible means should be employed to clear the ducts at the initial operation. The exploration should include the hepatic as well as the common duct. The ampulla, also, should be thoroughly searched with scoops for any possible stones hidden within its recesses. In addition, the patency of the distal end of the duct should be demonstrated with a probe; not until this has been done may one feel reasonably sure that the patient will have no further trouble. Should an obstruction be found at this point, the sphincter may be dilated almost to the size of the normal common duct without injury and with little fear of subsequent contraction, provided one uses bougies of graduated size. Finally, it is our practice to institute drainage by means of a T-tube. The tube is brought out through a stab wound in the side and is not withdrawn until bile flows freely into the intestinal tract and there is no obstruction in the biliary tree, as determined by cholangiograms.

Following choledochostomy, we have given Decholin for an indefinite period, at first intravenously and then by mouth. This, or some other cholegogue will be found helpful in stimulating the flow of bile and permitting better drainage.

During the past fourteen years, we have performed a total of 863 operations upon the biliary tree, 819 of this number having been for benign disease of the gallbladder and ducts. Of the 819, operation was limited to the gallbladder and ducts in 803, of which 750 were primary operations and 53 were secondary. Six hundred eighty-two, or 85 per cent of the operations were upon the gallbladder alone, while the ducts were opened and drained in 121, or 15 per cent of the 803. Ninety-seven of the choledochotomies were primary and 24 were secondary. These findings are shown in Table I.

TABLE I

OPERATIONS IN 803 CASES OF BENIGN DISEASE OF THE GALLBLADDER AND DUCTS

| | | MORTALITY |
|---|---|---|
| Primary gallbladder operations without choledochotomy | 653 | 17 (2.6%) |
| Secondary gallbladder operations without choledochotomy | 29 | 2 (7%) |
| Primary gallbladder operations with choledochotomy | 97 | 9 (9.3%) |
| Secondary gallbladder operations with choledochotomy | 24 | 5 (20%) |
| *Totals* | 803 | 33 (4.1%) |

The 19 fatalities following operations upon the gallbladder alone constitute approximately 2.8 per cent of the 682 in this group, whereas the 14 fatalities following the 121 combined gallbladder and duct operations constitute 11.6 per cent. Thus, the mortality was more than four times higher in the latter group. This is probably due to the fact that stones are usually associated with long standing disease in which other structures have become involved.

In Table II is shown the total number of operations upon the gallbladder and ducts and

the respective number in which stones were found.

TABLE II
INCIDENCE OF STONES IN 803 CASES OF BENIGN DISEASE OF THE GALLBLADDER AND DUCTS

| | |
|---|---|
| Gallbladder operations | 803 |
| Stones | 515 (64.1%) |
| Choledochotomies | 121 |
| Stones | 94 (70%) |

For purposes of comparison, and to show our more recent experience, we have divided the entire 803 operations into three groups: Those performed from October, 1932, to June, 1941, from June, 1941, to October, 1943, and from October, 1943, to May, 1946. The number of gallstones and duct stones in the three groups, respectively, are shown in Table III.

A third problem arises in those cases wherein choledochotomy itself is inadequate to relieve the obstruction. Occasionally, one encounters a stricture of the distal end of the duct which is not amenable to dilatation. The duct is distended from bile stasis, and following drainage, the stasis and distention may be expected to recur. One's only course, therefore, lies in some type of side-tracking operation to insure passage of the bile into the intestinal tract. A similar situation may be presented by obstruction incident to any type of benign or malignant lesion of the ducts or pancreas.

TABLE III

COMPARATIVE REVIEW OF 803 CASES OF BENIGN DISEASE OF THE GALLBLADDER AND DUCTS

| | *Gallbladder Operations* | *Gall-stones* | *Duct Operations* | *Duct Stones* |
|---|---|---|---|---|
| *Group I* 1/1/32-6/1/41 | 383 | 215 (56%) | 35 (9% of 383) | 26 (74% of 35) |
| *Group II* 6/1/41-10/1/43 | 192 | 113 (59%) | 42 (21% of 192) | 28 (66% of 42) |
| *Group III* 10/1/43-5/1/46 | 228 | 187 (82%) | 44 (20% of 228) | 40 (90% of 44) |
| *Totals* | 803 | 515 (64.1%) | 121 (15% of 803) | 94 (78% of 121) |

Our mortality in the first group was 5 per cent; in the second group it was 3.1 per cent and in the third group, 3.5 per cent.

As will be observed, the percentage of gallstones recovered was considerably higher in the third group than in the previous two, showing that we have restricted surgery much more closely to cases in which stones were demonstrated. We believe this has some bearing upon the significant fact that, although the percentage of our choledochotomies has not materially increased within recent years, the finding of stones in the ducts has increased from 66 to 90 per cent. That stones were found in 90 per cent of only 20 per cent of choledochotomies indicates that the number of choledochotomies performed is of far less importance than the care with which one observes the criteria for the procedure. From this experience, we do not see the necessity of subjecting patients to choledochotomy without clear indications.

In view of the serious risk, the operation in such cases should be selected with a view to its simplicity. We have found that choledochoduodenostomy is most suitable, in that it is not only comparatively simple from the standpoint of technic, but is physiologic in principle and thus offers a wide margin of safety. All the bile is immediately made available in that portion of the intestinal tract where it normally empties, intestinal function is soon restored, and the patient's convalescence is commensurately shortened.

Another important advantage of choledochoduodenostomy lies in the fact that the intraluminal pressure between the biliary tree and the intestinal tract appears to be equalized following operation. It is well established that intraductal pressure incident to obstruction

leads not only to pathologic changes in the liver, but to venous stasis. The rapid release of the obstruction, with the sudden flow of blood into the impaired hepatic vessels may give rise to intense hyperemia, with further circulatory disturbance and additional damage to the liver. This effect, manifested by serious toxic symptoms, has been observed in deeply jaundiced patients following choledochotomy and drainage to the surface. With the use of choledochoduodenostomy, decompression of the ducts takes place more slowly, the ductal pressure is thus equalized by that in the intestinal tract, and this complication is avoided.

The first criterion for choledochoduodenostomy is that the duct must be sufficiently large to permit an adequate stoma. Second, the duct must be of ample length above the obstruction to permit anastomosis without tension, or, one must be able to mobilize the duodenum to a sufficient extent. If the duct is not enlarged and the condition of the gallbladder and cystic duct permits, cholecystoenterostomy or cholecystogastrostomy is preferable. We feel, however, that the use of the gallbladder for anastomosis in the presence of infection is contraindicated. The gallbladder is a poor conductor of bile and the infectious process induced by chronic bile stasis cannot be counted upon to become quiescent and remain so: if the infection and inflammation persist, the walls become thickened, closing the stoma and leading to a recurrence of the biliary obstruction. The possibility of extension of the infection into the cystic duct and consequent occlusion of its lumen is a further argument against anastomosis with the gallbladder.

We have become convinced of the superiority of choledochoduodenostomy in the presence of an enlarged duct containing multiple small stones, sand and muddy material, when the distal end cannot be dilated sufficiently to insure *continuous* and *ample* drainage. Moreover, the dilated area tends to contract again and bring about another impediment to the outflow of bile. This leads to the reformation of the stones and sandy material, the original clinical picture is reproduced, and a second operation becomes necessary. Such a condition frequently develops even after choledochostomy. Following choledochoduodenostomy, on the other hand, there is little likelihood of the reaccumulation of sand and stones. The distended duct lends itself well to the creation of an anastomosis sufficiently wide practically to insure continued and adequate drainage.

A striking demonstration of the desirability of this type of operation as a primary procedure when the common duct is distended and the outlet difficult to dilate fully, was shown in the case of a woman, aged 61, who had chronic cholecystitis with obstructive jaundice. The gallbladder was quite diseased, but contained no stones. Small bile cysts and biliary abscesses were scattered throughout the liver. The common duct was five or six times normal size, but no stones could be palpated. After removal of the gallbladder, the duct was aspirated and then opened and a large quantity of muddy bile filled with sand and numerous small stones was removed. The hepatic duct was thoroughly explored, though no stones were found. The distal end of the common duct was dilated and a T-tube left in the duct. Bile drained through the tube for two weeks and, following its removal, continued to drain through the incision. The stools had practically no color, showing that most of the bile was coming to the surface. The patient also became slightly jaundiced. Apparently, the distal end of the duct was again obstructed. The fistula persisted, and five months after the first operation the abdomen was reopened and the fistula followed down to the common duct. The duct was still quite distended and, when opened, a large amount of thick, sandy material escaped, with many small stones from the hepatic duct. After a thorough cleansing of the ducts, an attempt was made to pass dilators through the papilla of Vater, but without success. The duodenum was then freed and widely anastomosed to the duct above the sinus. The anastomosis functioned perfectly, all the bile passing into the intestinal tract, and the jaundice promptly cleared. The patient had no further disturbance referable to the biliary tract to the time of her death from another cause, three years later.

Except in injuries of the common duct or when a portion has been removed, it is our custom to make a lateral anastomosis in performing choledochoduodenostomy, the duct as well as the duodenum being incised in the longitudinal direction. In the presence of injury or obstruc-

tion of the hepatic duct, if the remaining length above will not permit a lateral anastomosis, one will, of course, have to unite the end of the duct to the duodenum. We have used this procedure in 3 cases, anchoring the duodenum to the liver around the anastomosis to prevent leakage. The result was excellent in all three. In still another, more recent case, we followed the technic suggested by Allen, wherein the jejunum is divided, the distal end sutured over a catheter to the end of the hepatic duct in the liver sulcus and anchored to the surrounding liver surface and the proximal segment of the jejunum is united to the distal end at a lower level, after the method of Roux. This operation is designed to preclude ascending infection from the intestinal tract, with its complications of cholangitis and ultimately the formation of liver abscesses and complete hepatic dysfunction. A similar technic, having the same purpose, has been presented by Cole and his associates. We feel sure that both these procedures are worth while, though the patient for whom we performed the Allen operation has continued to have difficulty to the present time, six months later.

We have performed choledochoduodenostomy in 26 cases and hepaticoduodenostomy in 4, a total of 30 cases. Twenty-three of the 30 were for obstruction by stones, stricture or pancreatitis, or for injury of the ducts. Two were for carcinoma of the pancreas and 2 for carcinoma of the ducts, while in 3 cases we could not be sure whether the obstructing lesion was a carcinoma of the pancreas or a severe pancreatitis. (Table IV.)

TABLE IV
TYPES OF LESIONS AND MORTALITY IN 30 CASES OF CHOLEDOCHODUODENOSTOMY AND HEPATICODUODENOSTOMY

| | *Cases* | *Mortality* |
|---|---|---|
| Carcinoma pancreas | 2 | 0 |
| Carcinoma ducts | 2 | 0 |
| Carcinoma pancreas or pancreatitis | 3 | 0 |
| Benign obstructive lesions | 23 | 2 (8.7%) |
| *Totals* | 30 | 2 (6.6%) |

Eleven, or 37 per cent, of the 30 patients had had a previous operation, and 7 of these had a biliary fistula. In 3 cases, both operations were performed by us.

There were 2 postoperative deaths in the series. One patient, a many aged 73, died of a pulmonary complication following a second operation. The other patient, operated upon 18 years ago, died from other cause.

Eight patients have died since their dismissal from the hospital. Five of the 8 had malignancies and succumbed to the effects of the disease. Three had benign lesions, but died months or years later of other causes. Of the remaining 20, 16 had choledochoduodenostomies for benign obstructions of the duct. One of the 16, who had a hepaticoduodenostomy as mentioned previously, has been only slightly relieved. The other 15 have remained entirely well, not one having had any disturbance indicating an ascending infection or further obstruction.

TABLE V
RESULTS IN 30 CASES OF CHOLEDOCHODUODENOSTOMY AND HEPATICODUODENOSTOMY

| | Patients | Died postoperatively | Died subsequently | Living |
|---|---|---|---|---|
| Choledochoduodenostomy | 26 | 2 (7.6%) | 7 | 16 (60%) |
| Hepaticoduodenostomy | 4 | 0 | 1 | 3 (75%) |
| **Totals** | 30 | 2 | 8 | 19 (63%) |

*Summary*

The gallbladder and duct problem concerns, in the main, the indications for cholecystectomy and for open exploration of the common duct, in that much of the success of the operation depends upon the care with which these indications are observed.

The chief difficulty in determining the necessity for removal of the gallbladder arises in the noncalculous type of cholecystitis. Here, one must decide whether the symptoms are in reality related to a diseased gallbladder, to disease of some other organ, or merely to nervous stimuli. A penetrating history and exhaustive studies may be required in settling this question. In the presence of stones, the indication for operation is clear. Even though the stones may be producing few symptoms, sound surgical opinion is in favor of removing the gallbladder as a precautionary measure.

Once the indications are established, the sooner operation is undertaken the better. Extension of the pathologic process to the ducts, liver and pancreas, commonly encountered in long standing disease, may lead to serious consequences. The danger of an acute attack and a possible perforation are further arguments for early surgical interference.

In the presence of an acute attack, the choice between immediate and delayed operation is the

foremost problem. In the vast majority of cases, the attack will subside under appropriate treatment, permitting operation at a more advantageous time. One can usually tell what course the acute process is going to take within 24 to 36 hours after the onset. We regard sustained abdominal pain and a tender mass as positive indications for surgery. The need is urgent when abdominal rigidity, an elevation of temperature and a rising leukocyte count are found, pointing to a fulminating infection.

The findings which, in our opinion, justify open exploration of the common duct consist of (1) palpation of a stone, (2) abnormal dilatation of the duct, (3) a contracted gallbladder, (4) multiple stones in the gallbladder with an enlarged, patent cystic duct, (5) jaundice or a history of jaundice, and (6) flocculent bile in the duct as determined by aspiration. By discriminating adherence to these criteria, we have found it necessary to open the ducts in only 20 per cent of our operations upon the biliary tree. The wisdom of this course has been borne out by the fact that, within recent years, we have recovered stones from the duct in 90 per cent of our choledochotomies.

In those cases wherein drainage of the common duct is inadequate and some type of sidetracking operation is necessary to insure passage of the bile into the intestinal tract, we prefer choledochoduodenostomy with a lateral anastomosis. This procedure is suitable to obstruction of the outlet of the duct from any cause, being particularly advantageous in the presence of an enlarged duct containing multiple stones, sand and muddy material, when the distal end cannot be dilated sufficiently to insure continuous and ample drainage. The only requirement is that the duct be sufficiently large to permit a wide stoma. The fact that the technic is comparatively simple, and that it is physiologic in principle, thus offering a wide margin of safety, commends choledochoduodenostomy for use in preference to other procedures having a similar purpose.

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# CORRECTIVE SURGERY OF THE EXTERNAL NASAL PYRAMID AND THE NASAL SEPTUM FOR RESTORATION OF NORMAL PHYSIOLOGY

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## I.

### INTRODUCTION TO INDIVIDUAL PROCEDURES FOR SURGERY OF EXTERNAL NASAL PYRAMID

## II.

### SURGERY OF ANTERIOR AND POSTERIOR PORTIONS OF NASAL SEPTUM

## III.

### SURGERY OF EXTERNAL NASAL PYRAMID COMBINED WITH SURGERY OF THE NASAL SEPTUM

Deformities of the nose frequently interfere with normal breathing by producing nasal obstruction and changing the course, quantity, and the pressure of the air currents. They are caused chiefly by injuries and by developmental abnormalities and occur in any and all parts of the nose especially in the external nasal pyramid and the anterior and posterior portions of the septum.

The correction of these deformities obviously should be done by those thoroughly trained and experienced in all phases of Rhinology but unfortunately patients needing nasal relief have frequently gone outside of our specialty for help. Oral surgeons and general plastic surgeons are consulted who generally operate on the visible deformities and leave the internal ones uncorrected.

The chief reason in our opinion for Rhinologists not doing more of this work is the fact that within the circles of our specialty there have been very few who were prepared to offer sound guidance and systematic instruction in the surgical procedures which have to be learned and mastered before consistently good work can be accomplished. Most of our colleagues who do this work well have had to learn the hard way — digging it out for themselves, by trial and error, over many years.

It has been left to a man, whose chief interest

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in medicine for 40 years has been teaching, to analyze our problems and bring us a scientific understanding and solution.

We are greatly indebted to Dr. Fomon of New York for the knowledge and inspiration which he has imparted to all those who have come to him seeking information and instruction.

We wish at this time to pay him homage and extend our deep appreciation for his talented work, his highly gifted pedagogy and his most generous desire to share his knowledge.

Dr. Kernan of New York in a talk delivered recently in New York said that Dr. Fomon had added a brain to the fingers of the Otolaryngologist and we may say as a corollary that thinking through the analysis of specific problems is infinitely more difficult than acquiring the skill required to perform the necessary corrective operations.

I.

Corrective surgery of the nose includes consideration of surgery of the external nasal pyramid in addition to surgery of the septum.

*Anatomy.* — The external nasal pyramid from a surgical point of view is divided into the bony vault, the cartilaginous vault and the lobule. The latter in turn is further divided into the tip, the alae and the columella.

The bony vault is made up of the nasal bones and the frontal processes of the superior maxillae united in the midline onto the perpendicular plate of the ethmoid. In the adult white person the nasal bones extend caudally beyond the ventral juncture with the ethmoid plate while in young individuals and in some other peoples such as the Chinese the plate extends anteriorly beyond the smaller nasal bones.

Attached to the under sides of the bony vault are the upper lateral cartilages. These in reality are the wings of the septal cartilage of which they are an integral part and together with which they constitute the cartilaginous vault.

Lying over the caudal end of this vault is the lobule.

In each side of the lobule is the horse-shoe shaped alar cartilage consisting of a lateral crus, dome and a medial crus. It is commonly referred to as the lower lateral cartilage. The lateral crus does not extend more than half way down the side of the lobule and ends in the fibrous fatty substance of the ala. Ventrally it turns abruptly to form the angle or dome of the cartilage and continues dorsally on its own side of the free caudal end of the septum, half way down in the columella as the medial crus.

The cephalic borders of the lower lateral cartilage lie over (ventral to) the caudal margins of the upper lateral cartilages. This can be seen by retracting the alae and identifying the region known in the text books as the limen vestibuli. It must be noted moreover that there is no continuity of bone or cartilage between the lobule and the rest of the nose.

The columella extends in the midline from the tip of the nose to the lip. As mentioned above, in its ventral half, the medial crus on each side lies just beneath the skin; the free end of the septum pushes into the dorsal half nearly always separating the medial crura and extending to the nasal spine of the maxilla at the naso-labial angle.

Cephalically the columella is attached to the septum by the membranous nasal septum which fact guarantees its free mobility.

The details of the anatomy of the septum need no further mention here. What is referred to as the anterior portion of the septum is that portion anterior to an imaginary line drawn between the nasal spine of the frontal bone and the nasal spine of the maxillae. In other words it is the cartilaginous septum which underlies the cartilaginous vault.

*Principles Of Corrective Surgery Of The Nose.* — To relieve an obstruction or redirect an air current it can be seen that tissues may have to be removed, replaced or reset.

A given part may need to be trimmed, mobilized and put into a new position or replaced entirely or in part and repositioned. All affected and related parts of the nose may need to be modified and mobilized and if possible should all be done at the same operation.

Post-operative scar formation influences considerably the result obtained on the operating table — so that the attempt is made to leave no bare areas and to bring all raw surfaces into contact with tissues which will yield the least to the force of the contraction of scar tissue.

All procedures must contribute to improving nasal function and must not be based only on anatomic or esthetic considerations.

*Surgery.* — The surgical approach to the ex-

ternal nasal pyramid has been well described by Fomon[1] and we shall just briefly outline the details here.

1. *Uncovering Bony and Cartilaginous Vault.*
   a. *Incision.*
      Ala retracted and an incision made in linen vestibule.
   b. *Uncovering Cartilaginous Vault.*
      With sharp double edge knife — the skin is separated as close to the perichondrium as possible. (The fingers of the other hand on the outside of the skin acting as a constant guide).
   c. *Uncovering Bony Vault.*
      With Mackenty or/and Joseph periosteal elevators the periosteum of the nasal bones is separated almost up to the naso-frontal angle. All fibrous and muscle bands connecting the skin to the underlying hard parts are carefully sought for and severed with scissors or knife. Care is taken to leave as great a thickness of skin as possible and never to puncture the skin.
2. *Separating the Lobule.*
   The columella is retracted caudally by means of a forceps or traction suture. A dull ended knife is passed through the original incision on one side over the bony cartilaginous vault into and through the original incision of the other side. The knife now cuts caudally until it reaches the caudal end of the septum and then is turned 90° dorsally and hugging the caudal end of the septum the incision continues through the membranous septum as far as is feasible. The knife is withdrawn and the incision extended with a Mayo scissors to the floor of the nose on each side just anterior to the spine of the maxillae.
3. *Trimming Caudal End of the Septum.*
   For deformities of this part such as twists and excessive lengths a portion can now be removed entirely or mobilized as will be described later.
4. *Breaking the Spring of the Bony Vault.*
   A chisel is inserted at the junction of the bony and cartilaginous vaults between the nasal bone and the septum on each side and with a few taps of a hammer is carried cephalad short of the bridge of the nose (the "solid angle") (always under guidance of the fingers of the other hand — feeling the chisel through the skin). If a hump on the nose is present and its elimination planned its removal will automatically break the bony spring. To remove the hump a saw is passed through the original incision and placed in contact with the bony vault at the desired level. This level may be predetermined by study of cast and pictures before the operation and may be aided by the use of angle guides, which indicate the direction and location of the saw cut. After the saw cut is well started the handle is moved laterally and the saw passes over the midline and the nasal bone of the opposite side is cut together with the perpendicular plate of the ethmoid. When the cartilage is reached the saw is withdrawn and the button-end knife is replaced to complete the removal of the hump through the cartilage. The hump can now be withdrawn with forceps (and similarly replaced at a later time if necessary).
5. *Freeing Lateral Attachments of the Bony Vault.*
   A small sagittal incision is made in the vestibule near the floor of the nose on each side just over the pyriform aperture. A Joseph elevator is introduced between the superior maxilla and its periosteum and the latter elevated almost up to and just medial to the internal canthus of the eye. The elevator is taken out and the periosteum held free with a Mackenty elevator and a right angled saw introduced. A saw cut is made almost through the maxilla in the most lateral portion of the exposed bone. The bones are now held in place only at their cephalad attachments.

   One thumb is placed well over the bone to be mobilized and with the other thumb over the first — gentle pressure breaks the upper attachment and the bone is made to approximate the septum on each side.
6. *Delivery of Lower Lateral Cartilages.*
   An incision is made through the vestibular skin just over the caudal border of the lower lateral cartilage. Over the medial crus the incision need not descend more than 3-4 mms.

The cartilage is separated from the ventral skin by Stevens scissors extending upwards into and connecting with the original incision.

A small sharp hook pulls the cartilage down while with a double hook retractor the skin over the lateral crus and dome is retracted up. A Neivert or Kaiser hook now pulls the cartilage down by its cephalic border in the region of the dome and holds it in front of the lobule. The cartilage and vestibular skin are cut through with a knife. After any necessary further freeing the upper borders of the lateral crura are trimmed. The medial crura are similarly mobilized and trimmed and if indicated may later be sewn to each other.

7. *Columella.*

The columella may be modified by insertion of grafts (Figure 4 and Figure 5) to act as battens and by correcting the caudal end of the septum. It may be narrowed by removing tissues from the exposed subcutaneous areas and subsequent through and through suturing.

When adequately prepared it is reattached to the caudal end of the septum in the same position or more ventrally thereby making the tip more prominent or dorsally thereby diminishing the projection of the tip.

8. *Trimming Upper Lateral Cartilages.*

The upper lateral cartilages have been partly or completely separated from the septum by the removal of the hump. If they are still attached, they are cut close to the septum with a scissors — or even better, with a knife — the skin meanwhile is retracted by an angular retractor which also protects the skin from injury.

If the nose has been shortened at all, the upper lateral cartilages will be seen projecting into the vestibules. They must therefore be shortened — the amount of shortening is determined by the level of the original skin incision.

The cartilages may also rise above the dorsum of the nose and require trimming along their ventral borders where they will become reattached to the ventral edge of the septal cartilage, and to each other.

9. *Mobilizing Alae.*

To free the alae incisions are usually made somewhere in the alar labial folds beginning laterally and terminating in the vestibule. Wedges (of various shapes) are removed and the alae reattached by sutures into the positions preferred. A transplantation of the alae outwards can also be effected by the moving of a skin flap inwards to cover the newly created raw surface.

10. *Dressing.*

A splinting dressing with adhesive strips and Stent Compound helps to hold the parts in place after the nose is cleaned, packed and moulded into the form desired.

II.

*Septum.* — To increase and improve breathing space in the nose by correcting deformities of the nasal septum, the typical sub-mucous resection as described by Freer[2] is the operation most commonly employed.

Generally speaking this has been frequently adequate and successful but, on the other hand, only too often have failures and disappointments been the experience of both patients and Rhinologists.

This should not be unexpected when one remembers three outstanding facts:

1. Deformities of other parts of the nose interfering with respiration are frequently overlooked.
2. The operation is usually limited to the posterior 2/3 of the nasal septum and leaves undone any correction of the anterior portion of the septum which very frequently requires surgical attention.
3. There are several sequelae and complications following the operation which must be avoided. Some of these follow:
   a. The orginal incision, through the mucous membrane leaves a scar and predisposes the mucosa during the operation of difficult cases to fairly easy tearing with subsequent further scar formation and large or small perforations.
   b. When cartilage and bone are not replaced, contraction of the submucosal tissues often diminishes the blood supply and thereby impares the function of the mucosal surface elements, even if the flaps are intact. Secondary atrophic rhinitis often follows.



Figure 1. Whole nose flattened and widened by injury.



Figure 1. a. Correction by extensive septum surgery combined with free mobilizing of external nasal pyramid.

c. If the septum gives much with the respiratory movements, the paths of the air currents are not fixed and the patient may complain of difficulty in breathing and impaired sense of smell.

d. The removal of all the hard septum elements may leave more room in the nose than the mucosa can handle so that replacement of these tissues becomes of greatest importance as the patients may still continue to complain of nasal obstruction.

e. We are taught and have learned by experience that an extensive removal of the cartilage beneath the arch of the cartilaginous vault results in a sagging of the dorsum and in many instances to a marked dropping of the lower half of the nose. This we are told is due to the removal of the supporting prop — the cartilaginous septum.

It is the contention of Dr. Fomon and his associates in which we concur that it is the contraction of scar tissue that creates these post-operative deformities. Freer was the first to express this view in his original article on Septum Surgery in 1902.

f. A disadvantage of the standard septum operation is that the approach is usually at the so-called mucocutaneous junction or often even more posterior. This practically limits all visibility to the operating surgeon and restricts seriously any assistance which he may be given.

It is our experience that it is feasible to do a conservative or extensive sub-mucous resection of the nasal septum with the following assurances:

1. Minimal injury to the mucosa — most frequently none at all.
2. Bone and cartilage may be replaced and the rigidity of the septum restored with ease.
3. Sagging of the cartilaginous vault may be prevented and even corrected if present.
4. Wide and ample exposure may be used making assistance available.

We do the septum operation as follows:

1. *Incision*:

The columella is pulled gently away from and to the left of the caudal end of the septum. This defines the edge of the septum on the right side. One-eighth of an inch behind this edge the incision is made through the skin and down to the cartilage on this side. The cut is made in two movements. Each approaches the middle, one starting from the tip area and the other from the region of the nasal spine of the maxilla. The skin of the ala may be pro-





Figure 2. Anterior septum incision. Just behind caudal end of septum. (Above)

Figure 3. a. Reflection of right and left mucosal flaps with sharp dissection. (Right, above)

b. Left flap only reflected. Dotted line indicates incision through cartilage through which elevation of right flap may be started. Caudal end of septum is thus retained.

c. Both flaps partly elevated and freeing caudal end of septum which can now be removed at dotted line.

tected with a lid retractor. (Figure 2).

2. *Elevation of the Left Mucosal Flap.*

The columella is retracted to the left. The caudal end of the septum covered by fibrous tissue now lies exposed. Keeping the tissues stretched the fibrous layer over the septum edge is cut, and the left side of the septum begins to be seen. With a straight, sharp, round ended knife (such as the Straight Freer septum knife or the one illustrated, Figure 3) held almost perpendicular to the septum the first one-eighth inch of the cartilage is exposed. It is a great help to hold the cartilage steady by means of a hook passed through the thickness of the cartilage and the right mucosa. Too much pull will cause the hook to tear through the tissues. Not until the blue color of the cartilage is well seen should one continue the elevation posteriorly. The mucosa just ventral to the center of the incision is frequently the easiest to elevate first. Having exposed the first one-eighth inch of the cartilage one can with assurance continue with the sharp knife-elevator to separate the first one-half inch. The skin-mucosa over the first one-half inch of the septum is very adherent especially near the nasal spine and careful sharp dissection and separation is imperative. After this

Figure 4. Insertion of cartilage graft into columella pocket through anterior septum incision with special graft forceps. (Left, below)

a. Superior end placed into vestibule.

b. Inferior end is then placed into pocket.

c. Rest follows — Graft is well covered with skin.

Figure 5. Sutures placed closely back of graft — leaving free skin posteriorly. (Right, below)





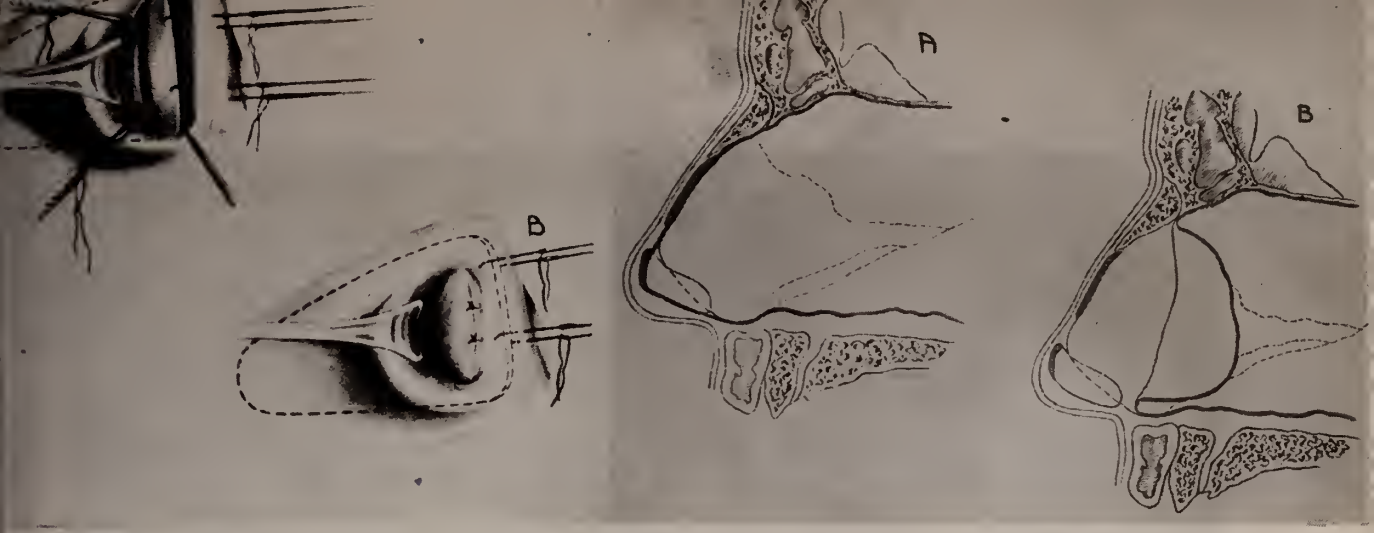




Figure 6. Replacing large piece of cartilage between mucosal flaps and into columella pocket.

a. Guide sutures pull cartilage into columella pocket.

b. Incision closed with sutures — Guide sutures may now be removed.

Figure 7. a. Anterior attachments of septal mucosa to nasal bones, upper lateral cartilages, and columella.

b. These attachments severed — Mucosa elevated from septum — Mucosal flap collapses.

the usual elevation (with sharp or dull, forward or backward elevators) is completed.

3. *Elevation of Right Mucosal Flap.*

This is done in two ways depending on whether or not the caudal portion of the septum is involved.

a. *Caudal End of Septum "Not" Included in Operation.*

The blades of a nasal speculum are inserted between the cartilage and the left flap and an incision in the cartilage is made caudal to the deformity which is to be corrected. Through this cartilage incision the right flap is elevated as in the typical Freer operation, which then may be watched through the right nostril or by direct vision between the mucosal flap. (Figure 3B).

b. *Caudal End of Septum Included in Operation.*

The elevation of the right mucosal flap

Figure 8. a. To preserve anterior-inferior attachment — original incision in mucosa does not extend ventrally to the "dorsum" thus leaving a connection between mucosal flap and columella. (No incision is made in the other flap). (Left, below)

b. Mucosal flap is held up well if upper lateral cartilage attachment u is preserved. (Compare with 7 b.)

Figure 9. a. Medial crura sutured to each other after separation from lateral crura (Reinforces inferior attachment of mucosal flaps). (Right, below)

b. Upper laterals sutured to each other and to mucosal flaps after separation from septum to preserve middle-anterior attachment of mucosal flaps. (Note all septal bone and cartilage has been removed).

c. After packing each side of the nose with gauze the flaps are held apart and bone and cartilage are replaced.

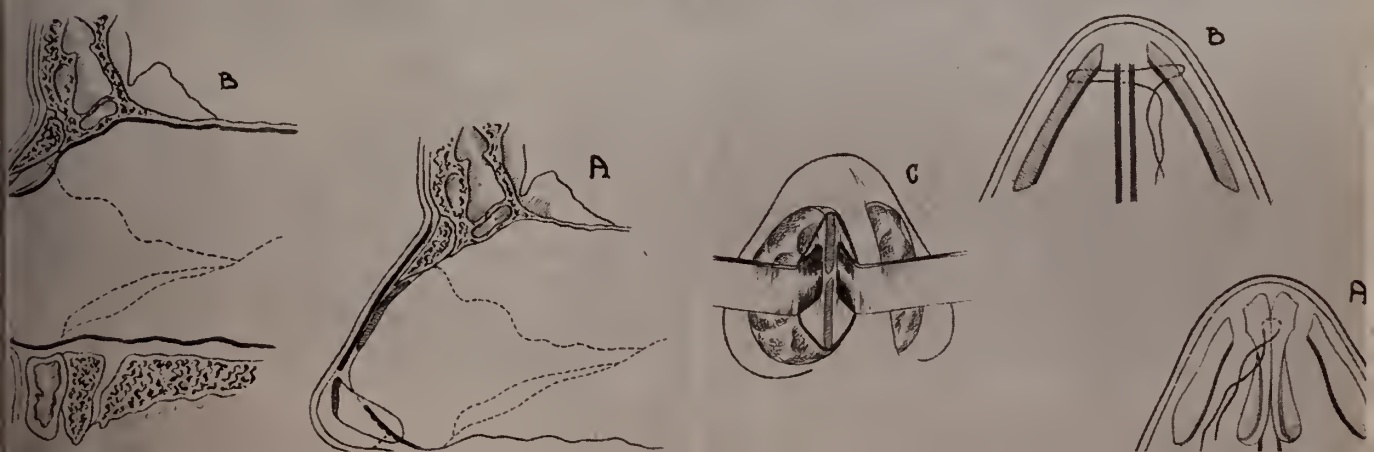




Figure 10. a. Nasal obstruction in a child due to anterior septal deformity.

Figure 10. b. After correction — note change of expression and that mouth is held closed.

is started just like the left one. After the first one-eighth inch is separated one or two stitches are placed through the mucosa to serve as retractors. The separation is then continued as on the other side — and may be watched directly by placing a long bladed nasal speculum between the cartilage and the right flap or via the right nostril as is done in the old operation.

4. *Removal of Cartilaginous and Osseous Deformities.*

Placing each of the two blades of a long Killian speculum on each side of the hard septum the mucosal flaps are held away sufficiently to permit the removal of any part or all of the cartilage and bone. Ordinarily there should be no hesitancy in removing completely all bone or cartilage which interferes with the normal passage of air through the nose. If there is a weakness of the nasal dorsum such as from a hump removal, congenitally small upper lateral cartilages or impaired upper lateral cartilages which may follow injuries and inflammations, a sagging of the cartilaginous dorsum may be anticipated and for this adequate reinforcing procedures are later instituted such as dorsal and septal grafts.

5. *Replacing Bone and Cartilage with Caudal End of Septum Intact.*

   a. Vaseline gauze strips are packed securely but not too tightly into each nasal cavity. The pieces of bone and cartilage which were removed are trimmed and thinned. The long nasal speculum is placed between the mucosal flaps, spread a little and the prepared pieces placed into position. If more material is needed preserved septal or rib cartilage may be used. The packing on each side will hold the grafts well in place. The edges of the incision are sutured.

6. *Replacing Bone and Cartilage when Caudal Part of Septum has been Removed.*

It is imperative to replace the cartilage of the anterior portion of the septum; not so much to provide a center support but to limit the amount of scar tissue which will form during healing and to give the scar



Figure 11. Hump and twisted nose with marked septum obstruction.



Figure 11. a. Corrected by extensive surgery of external nasal pyramid with surgery of the septum.

tissue some rigid tissue to which it will attach itself. The contraction of the scar tissue is the force that pulls the lower part of the nasal vault down. The contraction may also pull the cartilage more into one nostril than the other which emphasizes the need of separating both mucosal flaps equally — so that later scar contraction will be about equal on both sides. This explains some of the failures of the Metzenbaum operation where on one side the mucosal lining is not detached from the cartilage at all.

To replace this anterior piece of cartilage, Dr. Fomon introduced the following procedure:

A large piece of septal cartilage (2 x 4 cms. or larger) is fashioned from the removed tissue or if not available a preserved septal or rib cartilage is used. The edge of the selected cartilage which will become the caudal end of the septum is carefully trimmed to fit into a pocket prepared in the columella. Two double armed sutures are passed through the edge of the cartilage, one ventralwards and the other dorsalwards and the cartilage placed between the mucosal flaps well posteriorly. (figure 3). The needles then are passed through the columella pocket and are brought out through the skin ventrally and dorsally. By pulling on these sutures the cartilage is pulled anteriorly into the columellar pocket and guided into the position desired — and with 2 or 3 sutures through the septum joining the anterior and posterior edges of the original incision the graft is held in place and the guide sutures cut and removed (Figure 6). (Before fixing the graft in place the nose should be packed on each side as in procedure number 5 and the other pieces of cartilage or/and bone replaced as indicated).

It is possible to do this precedure with several small pieces of cartilage instead of one large piece. Though technically more difficult it is occasionally necessary. A batten is sewed into the columella pocket. (figures 4 and 5). Gauze packs will support the posterior pieces. A piece or several pieces of autogenous



Figure 12. Hump nose with twisted septum.



Figure 12. a. Correction of hump combined with complete septum surgery.

or isogenous cartilage can be secured anteriorly with sutures. Again the edges of the original incision should be sewn — the anterior part of the suture through or near the columella graft will hold well — the posterior part too will hold well if a piece of cartilage between the flaps is incorporated in the stitches. The sutures put into the right flap as retractors will assist greatly at this time.

Figure 13. Same as 12 showing caudal end of septum in left nostril.

Figure 13. a. Corrected at same time as hump removal.







Figure 14. Nose pushed to right (Automobile accident)



Figure 14. a. Corrected by extensive surgery of both the nose and the septum.

III.

*Combined Operation.* — The ultimate objective to be achieved with all the surgical procedures described is to combine them at will as may be indicated.

In general an extensive mobilization of the external nasal pyramid may be combined with a moderate amount of septal surgery and this is very often done if the peripheral ¼ inch of the septum is not disturbed and the removed parts are replaced.

Yet, if the external nasal pyramid is completely mobilized and septal bone and cartilage are extensively removed leaving only a mobile pair of mucosal flaps — there is nothing left for the support of the nose, and the facial portion of the nose will fall into the nasal interior.

The exigency arises however when just this much surgery must be done and all at one sitting. For example the case illustrated in figure 1 and 1a requires elevation of the nose and concomitant elevation (by straightening) of the multi-buckled nasal septum.

The feasibility of this combined operation depends upon maintaining ventral attachments for the correct suspension of the mucosal flaps. In doing a submucous resection the flaps are completely separated from bony-cartilage support. They do not fall because they are held in place by the reflection of the mucosa onto the lateral walls of the nose. Superiorly the mucosa goes from the septum to the inner surfaces of the nasal bones and superior maxillae and inferiorly from the septum onto the inner surfaces of the upper lateral cartilages. Beyond the caudal end of the septum the mucosal flaps are continuous with the membranous septum which in turn are continuous with the firmly attached skin lining of the columella on each side. At the root of the nose the mucosa continues posteriorly attached securely to the frontal spine, the inferior wall of the frontal bone and the cribiform plate.

Therefore if in a given case the mucosal flaps are completely elevated from the septum and in addition a transfixion incision is made and the upper lateral cartilages and the nasal bones separated from the septum — it must necessarily follow that the mucosal flaps will fall and collapse for want of support. (Figure 7A and 7B).

To prevent this the following precautions are taken:

1. Preservation and strengthening of inferior attachments.
   a. As in the septum operation described before, the incision for the septum operation is made in the right or left flap anteriorly but extreme care is taken not to extend the incision ventrally to where it will meet the incision over the upper



Figure 15. Nose broad and depressed following trauma and subsequent intranasal surgery.



Figure 15. a. Corrected by reconstruction of septum and external nasal pyramid.

lateral cartilage attachment to the caudal end of the septum. This provides an attachment from this flap to the columella on the right side. (Figure 8A).

b. After separating the left flap no transfixion incision is made at any time — which preserves the caudal attachment of this mucosa to the columella.

c. A cartilage strut or cancellous bone batten is sutured into the columella to stiffen and strengthen it.

d. The medial crura are separated from

Figure 16. Depressed tip, twisted septum remains following previous septum surgery (mask) corrected by combined septum and external nose surgery.



Figure 17. Collapsed cartilaginous vault corrected by simultaneous surgery of septum and external nasal pyramid.



the dome of the lower lateral cartilages and sewed together. This together with the reinforced columella — gives an adequate caudal attachment for the mucosal flaps. (Figure 9A).

2. Preservation of septal attachments to upper lateral cartilages.
   a. Attachments are not cut at all.
   b. Attachments are cut in part only; a cephalad, caudal, or a middle part is left intact.
   c. Attachments are sewed to each other and to septal flaps before or after they are separated. (Figure 9B).
   d. Upper lateral cartilages are cut (through ventral exposure) leaving mucosa continuity preserved.
3. Preservation of superior attachments.
   a. In the most superior region elevation of mucosa posteriorly is practically never needed nor done.
   b. Below, elevation of mucosa is not done over any portion of the bone which is not to be removed.
4. Support of mucosal flaps. Each nasal chamber is packed with gauze strips sufficiently to hold up mucosal flaps while operating. A long bladed nasal speculum will keep the flaps separated sufficiently when good visibility is needed. (Figure 9C).

The packs are not removed for several days after operation. We have left them in for as long as two weeks.

## CONCLUSIONS

1. Corrective surgery for the restitution of normal nasal physiology should be performed by adequately trained Rhinologists.
2. Deformities of the external nasal pyramid and the anterior part of the septum have in the past been neglected, a situation which is now rapidly being remedied.
3. Extensive pyramid and septal surgery may be combined when definitely indicated if provisions are made for attaching the septal mucosa to its anterior abutments.

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# ANTI-TUBERCULOSIS VACCINATION

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Since the days of Robert Koch there have been numerous attempts to prepare an effective specific vaccine against tuberculosis.[1,2,3,4]. None has been unequivocally accepted by the medical profession, some only had experimental trials in animals and then disappeared from the scene. All have been objectionable for one or another reason of more or less validity. It is to be admitted that the acquisition of a vaccine against tuberculosis would be valuable. We have ample evidence that the tuberculosis rate can be reduced materially by non-specific means; i.e., by raising living standards, thereby improving hygienic conditions. However, since this is not always practical and in many areas will not be an obtainable goal in the near future, it is necessary that the search for a vaccine be continued. Further, a vaccine that shows promise should be given an adequate experimental trial and be accepted or rejected on its merits.

The science of immunology was born in an effort to provide specific immunizing procedures against infectious diseases. Principles were discovered that have withstood the test of time and that have been successfully applied to the specific prevention of several infectious diseases of man and animals. These principles have now fallen into an orderly classification which may be summarized:

I. The use of bacteria themselves in the following states:
   A. Subinfective doses of fully virulent organisms.
   B. Avirulent bacteria attenuated by
      1. Continued artificial cultivation.
      2. Passage through an unnatural host.
      3. Exposure to mild disinfectants.
   C. Dead bacteria killed by
      1. Exposure to excessive heat.
      2. Exposure to chemical agents.
      3. Fragmentation.
      4. Asphyxiation.

or, II. The use of bacterial products derived by,
   A. Natural elaboration such as toxins, which may be used in

From the Tice Laboratories of the Municipal Tuberculosis Sanitarium and the Dept. of Pathology and Bacteriology, Chicago Medical School, Chicago.

1. A natural unchanged state, or
2. As a toxoid, which is toxin treated by
   a. heat — natural toxoid, or
   b. chemicals — formalin or alum.

B. Extraction of certain antigenic components in the hope that these will engender antibodies of a protective nature.

Many of these principles have been applied in attempts to find a suitable vaccine effective in preventing tuberculosis. Much of the work has been either negative or inconclusive. Utilization of subinfective doses[5] of fully virulent bacteria is obviously too dangerous as a purposeful procedure. However, the relative immunity resulting from a healed primary infection may be considered evidence that such a method might be effective but unfortunately cannot be practically applied.

The use of avirulent bacteria has had a considerable vogue. Only one vaccine has been used to an extent which allows evaluation of its efficacy as an immunizing agent. This is known as the Bacillus of Calmette and Guerin or BCG. About BCG we have a good deal of authoritative information which will be enlarged upon later.

Dead bacteria killed by heat have been used experimentally[6] and in human beings[7] with controversial results. The use of an immunizing agent in this form has certain obvious advantages and some not so obvious disadvantages. The bacteria are dead and, therefore, cannot of themselves initiate a progressive disease process. It is obvious then, that such an immunizing agent involves no danger. However, it is also apparent from the studies referred to above, that such an agent produces only a low-grade immunity of short duration. This is not surprising when one is cognizant of the fact that other bacterial agents of disease in the dead state are usually not efficient immunizing agents.

Of the various agents used to kill the tubercle bacillus for purposes of producing a vaccine, heat has been most prominent. Chemical agents and physical fragmentation have not been used to any great extent. However, von Ruck[8] utilized tubercle bacilli which had been fractionated by trituration and then the fractions mixed and used as a vaccine. In spite of the apparently good results reported in this work, there has been no follow-up in the literature. Some 700 children and adults were vaccinated with this material but there are no results recorded which allow for unbiased evaluation of the vaccine. Arima[9] since 1927 has been using a vaccine prepared from human tubercle bacilli allowed to die of starvation due to prolonged storage. The information about this vaccine known as the "A-O" vaccine is so spotty and the claims so fantastic that one is inclined to dismiss them until it can be made accessible to other workers. A recent report by Potter[10] introduces the use of tubercle bacilli killed by asphyxiation. This work is still in the animal experimentation stage although the results are promising. The principle involved in this type of vaccine is concerned with preserving the antigenic complex of the tubercle bacillus, a portion of which is presumably destroyed in a heating process.

Since the tubercle bacillus has never been demonstrated to produce a true soluble exotoxin it has not been possible to prepare an immunizing agent of this nature.

Since a fairly large literature has appeared concerning the vaccination of human beings against tuberculosis with BCG, it might be advantageous to review the origin and principles of this vaccine. BCG is an attenuated strain of a bovine tubercle bacillus isolated in 1908 from a tuberculous cow. It was subsequently cultivated on a medium composed of a potato slab impregnated with glycerinated ox-bile. After several years of continuous cultivation of this medium, the organism was found to have lost virulence for not only cattle but also for guinea pigs[11]. In 1913 experiments were begun to show the efficacy of this culture for the specific protection of cattle against tuberculosis[12]. Results of these experiments were considered so favorable that in 1922 human beings were vaccinated for the first time. Since that time several hundred thousand people have been vaccinated in many countries in the world, principally in France, Norway, Sweden, Denmark, Russia, Argentina, Brazil, Uruguay, Romania and Canada.

The principle involved in the utilization of BCG as a vaccine against tuberculosis is the same as that which supports the use of vaccinia to immunize against small pox; the use of an attenuated strain of the causative agent of a disease to produce active immunity without a production of the symptom complex or pathologic

lesions. This principle has been established as an efficient immunizing procedure in the prevention of such diseases as small pox and yellow fever.

As is well known there have been objections raised in this country to the use of BCG. These objections fall into two categories. First that the culture used for vaccination purposes may of itself be harmful. As is pointed out by Pinner[13] most authorities who are versed on the subject agree that the culture if properly handled is entirely harmless; i.e., that it cannot initiate a tuberculous process. However, it has been pointed out that administration of BCG to an individual creates an allergy to tuberculosis where none existed before which of itself is thought to be harmful by some.[14] That this is so is subject to controversy but the fact that BCG vaccination produces a relatively low-grade of hypersensitivity would make this objection of relatively little moment. It has also been pointed out that the creation of a positive tuberculin test following a BCG vaccination lessens the value of the tuberculin test as a diagnostic procedure in children. This is true but if the vaccine is efficacious we should be prepared to sacrifice this diagnostic procedure.

The second group of objections concern themselves with the possibility that the vaccine is ineffective as an immunizing agent. Objections of this kind are raised mainly on the basis of inadequancy and inaccuracy of human experimentation. The studies which have been published have been criticized for one or more of the following reasons:

1. Promiscuous vaccination of all new born with no controls and reporting a comparison of the incidence of tuberculosis in the vaccinated children with that of comparable age groups in previous years.

2. Vaccination of all new born children in one community and comparing the incidence of tuberculosis of the vaccinated group with that of individuals living in an adjacent community.

3. Where apparently adequate control groups have been utilized there has been inaccurate statistical analysis.

4. Vaccination of large groups and adequate follow-up studies of only a small fraction of the larger group resulting in loss of differences of statistical significance.

5. Some studies have indicated a favoring of vaccinated children over the control group as indicated by reports of fewer illnesses of all types in the vaccinated group as compared with the individuals in the control group.

It is to be granted that these criticisms are basically sound, however, it is remarkable that all available studies are unanimous in reporting that the incidence of tuberculosis is considerably less in the vaccinated children than among "controls".

There have been four experiments carried out in this country on a relatively small scale. The first of these was under the direction of Park[15] where a relatively small group of children was vaccinated with BCG and a second group was kept as controls. The two groups were under as equal environmental conditions as could be determined. The incidence of tuberculosis in the vaccinated children was significantly less than in the unvaccinated children.

A second experiment was carried out under the auspices of the United States Department of Interior among the Indians on several reservations.[16] In this study individuals were vaccinated from a few days to 18 years of age. Controls were obtained by inoculating alternate cases with placebos instead of vaccine. No attempt was made to predetermine the immediate environment of individuals accepted for study except that it was to be expected that they all came from a highly tuberculous milieu. The complete results of this study have not as yet been published. A preliminary report indicates again a significantly lower incidence of tuberculosis among the vaccinated as compared to the controls.

A third report was made by Overton[17] who vaccinated some 4500 individuals with BCG from 1928 to 1931 at Nashville, Tennessee. People vaccinated ranged in age from new born infants to young adults. In the period under study only one case of tuberculosis occurred. It is regrettable that this report gives no definite information on controls. However, the author leaves the impression that there was a larger percentage of tuberculosis in comparable age groups

TABLE 1
Comparison of Incidence of Tuberculosis In BCG Vaccinated and Non-Vaccinated Children*

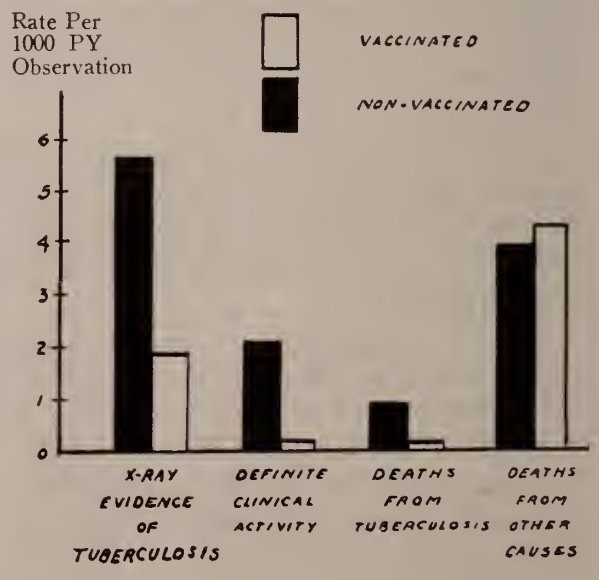
| | | Non-Contact | | Contact | |
|---|---|---|---|---|---|
| | | Vaccinated | Control | Vaccinated | Control |
| Total Number | | 1339 | 1323 | 136 | 96 |
| Person — Years Under Observation | | 5371 | 5419 | 417 | 215.5 |
| X-ray Evidence of Tuberculosis Clinically Active or Inactive | No. | 11 | 31 | 2 | 6 |
| | Rate per 1000 P-Y | 2.05 | 5.72 | 4.79 | 27.79 |
| Definitely Active Tuberculosis Requiring Hospitalization | No. | 1 | 12 | 1 | 5 |
| | Rate per 1000 P-Y | 0.18 | 2.21 | 2.39 | 23.20 |
| Deaths from Tuberculosis | No. | 1 | 5 | 0 | 4 |
| | Rate per 1000 P-Y | 0.18 | 0.92 | 0 | 18.56 |
| Deaths from Other Causes | No. | 23 | 21 | 2 | 0 |
| | Rate per 1000 P-Y | 4.28 | 3.88 | 4.79 | 0 |

*As of July 31, 1945.

in the community but gives no definite figures.

The fourth experiment was initiated in 1934 under the auspices of the Municipal Tuberculosis Sanitarium of Chicago.[17] In this investigation children were vaccinated by the multiple puncture route and controls were obtained by simply not vaccinating alternate children. The immediate environment of the children selected for study was determined by prenatal x-ray of the mother and all other members of the family. Table I summarizes the results of this study in the two groups of children; those not in contact with tuberculosis in their home environment, and those exposed to a known case of the disease. The results with the non-contact children are graphically illustrated in Chart I. It is to be noticed that in all stages of pulmonary tuberculosis from simple x-ray changes with no symptoms, to death from the disease, the incidence is significantly higher in the control group. The last column showing deaths from other causes is included to indicate that the vaccinated children were not favored. (A complete interim

CHART 1
INCIDENCE OF TUBERCULOSIS IN BCG VACCINATED AND NON-VACCINATED CHILDREN



report on this study has recently been published.[18])

It would seem fairly obvious that of all the different types of immunizing agents which have been used for purposes of preventing tuberculosis, the one which has offered the greatest degree of promise has been BCG. Objections which have been offered to its general use are not of a nature to condemn it. It is the opinion of a number of authorities that the vaccine should be made available certainly to children in families where there are known cases of tuberculosis, to children who live in highly tuberculous environments even though there is no known tuberculosis in the family, and voluntarily to all others. In addition it should be made available to adults whose occupation necessarily exposes them to tuberculosis, primarily nurses and medical students.

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## CARCINOMA OF THE MALE BREAST

Report of a Case


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Carcinoma of the male breast is a rare disease and comprises 0.1 per cent of all cancerous growths.[1] In the records of the tumor clinic of Provident Hospital for a period of 7 years there are 141 cases of carcinoma of the breast in a total of 460 cancers of all types. Two male patients had fibro-adenoma of the breast and one, the subject of this report, had both fibro-adenoma and carcinoma.

The patient, a man 59 years old, was first seen in the outpatient department on August 15, 1940. He complained of a sore on the left breast which he had first noticed two weeks previously. For two years he had worked with a pneumatic drill which he supported against his left breast. During the first year he used this drill irregularly, but during the second year he worked with it steadily. Itching was the first symptom, next was a painless swelling which, in two weeks, ruptured and discharged bloody fluid. In the past year his weight had fallen from 285 to 262 pounds.

The past and family history was not contributory. The only significant physical findings were in the left breast. In its lower medial quadrant there was a crater-like ulcer, about the size of a quarter, with a dirty, grayish floor. Its margin extended into the lower medial border of the nipple area. Immediately underneath was an indurated mass, fixed to the skin but not to the underlying tissue. The nipple was inverted. The right infraclavicular, supraclavicular and axillary nodes were not enlarged and no nodules were palpated in the right breast.

The patient was referred to the tumor clinic. A biopsy was performed August 19, 1940. The sections showed many atypical glands with hyperchromatic, anaplastic cells that showed a marked tendency to separate from the basement membrane and to collect in the lumens as ring-like, crescentic or irregular masses. Figure 1. In some fields there were dense collections of tumor cells in strands and irregular masses of various sizes with an abundant stroma of collagenous fibres. Figure 2. Also, there were superficial areas of necrosis with focal and diffuse infiltration of chronic inflammatory cells, chiefly lymphocytes and mononuclears. The sections were diagnosed as adenocarcinoma with infection and ulceration. On August 24, an x-ray examination showed old calcified

From the Tumor Clinic of Provident Hospital with the co-operation of Dr. U. G. Dailey, Chairman of the Tumor Clinic Committee and Mrs. Ruth B. Taylor, Medical Social Worker.

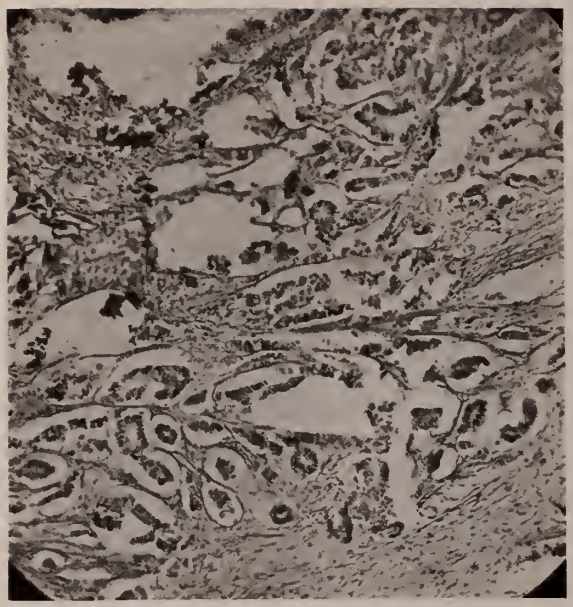


Figure 1. Photomicrograph of biopsy specimen showing adenocarcinoma with marked tendency of the anaplastic cells to separate from the basement membrane. Hematoxylin and eosin; x 300.

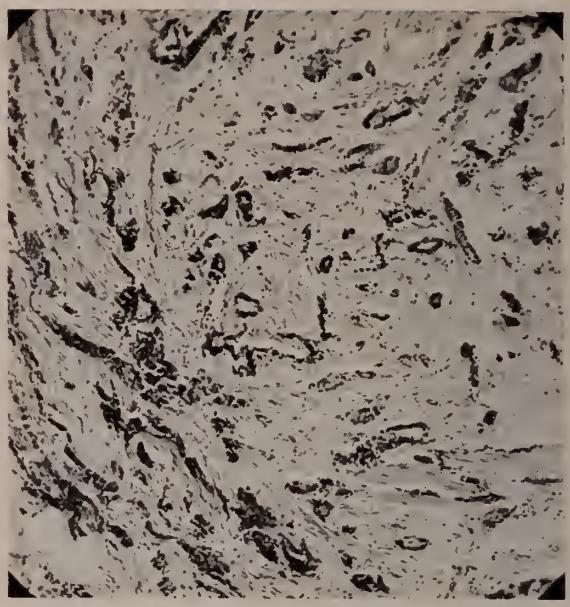


Figure 2. Photomicrograph of biopsy specimen showing adenocarcinoma with marked desmoplastic properties. Hematoxylin and eosin; x 300.



Figure 3. Surgical specimen showing inverted nipple and subjacent tumor.

hilal tuberculosis on the right but no evidence of metastases in the lungs or bones of the thorax. Two days later, Dr. Roscoe C. Giles did a radical mastectomy.

The surgical specimen was an amputated left breast with the attached pectoralis musculature. Figure 3. The nipple was deeply inverted and its lower medial margin was co-extensive with an ulcer, 13 mm. in diameter and 6 mm. in depth. Its floor and sides were granular and grayish red. Subjacent to the ulcer and surrounding skin was an indurated, pearly gray, irregularly shaped, non-encapsulated tumor with an inward extension of 4 cm. Its greatest length was 9 cm. and the greatest width was 4 cm. Its histological structure was similar to the biopsy specimen except that some sections showed fibroadenoma with marked cellular proliferation. Figures 4, 5, 6. Although the surgical report stated that a "mass of glands" was removed from the left axilla, no enlarged lymph nodes were found in the specimen.

X-ray therapy was recorded as follows: Approximately 10,000 "r" over 5 thoracic portals — 300 "r" per treatment daily. This treatment began September 24, and was concluded November 22, 1940. The patient visited the Tumor Clinic periodically until January 6, 1942. His weight then was 243 pounds and he complained of pain in the right chest. X-ray examination, however, failed to show any evidence of metastases in the thoracic cage. He was then a client of the Chicago Relief Administration and this agency was notified that he was able to do "any kind of work."

On May 29, 1942, he fell while walking in the street and struck his leg against the curb. He was taken to Cook County Hospital where the following diagnoses were made: "Pathological fracture in the upper third of the left femur with slight posterior displacement of the distal fragment. There is considerable rarefaction of the bone above and below the fracture site. There is evidence of extensive osteolytic lesions in the lateral margin of the right scapula and in the distal end of the clavicle and the upper end of the humerus.

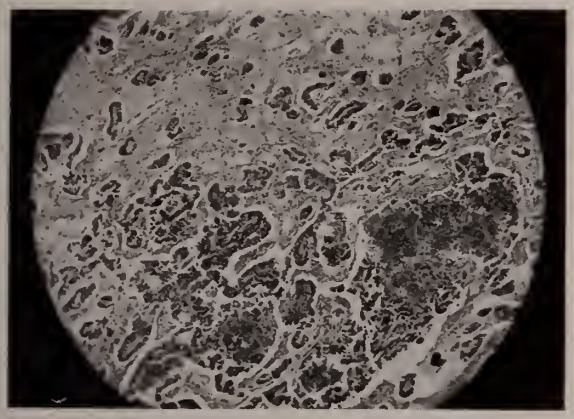


Figure 4. Photomicrograph of section of surgical specimen showing well developed adenocarcinoma. Hematoxylin and eosin; x 100.

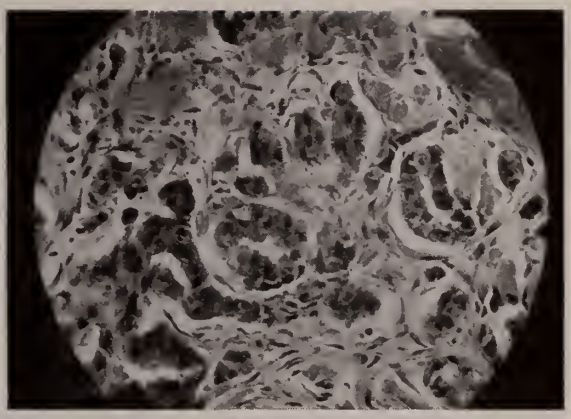


Figure 5. Higher magnification of Fig. 4 showing cellular structure and a cell in the anaphase of mitosis in the gland just left of center. Hematoxylin and eosin; x 400.

The findings suggest a metastatic malignancy." Death occurred in the County Hospital, September 10, 1942, two years and one month after the beginning of symptoms.

## COMMENT

According to Peck[2], the earliest reference to cancer of the male breast in medical literature was made by Franciscus Arcaeus (1493-1573). But the number of reported cases is comparatively small and the disease remains in the category of rare tumors. Geschickter recorded 30 cases in a series during a time that 2,524 cases of the female breast were observed. Wainwright[3] in 1927, collected 418 cases from the literature. Since then series of case reports have been made by Neal and Simpson[4], Gilbert[5], Moore[6], Sachs[7] and Peck. Recent contributions have also been made by Niethammer and Dublin[8] and also by Kunath[9].

In the large group of cases reviewed by Wainwright, the average age was 54.2 years which is approximately 4 years older than for female mammary cancer. The youngest patient was 22 and the oldest 91. The duration of symptoms averaged 29 months. Ulceration was observed in Wainwright's series in 38 per cent of the cases. The pathological varieties corresponded to those found in the female breast. Infiltrating lobular cancer was the most common gross form but the circumscribed forms of adenocarcinoma were approximately twice as frequent as in the female breast.

In 1944, Peck reported 43 tumors of the male breast, 15 of which were cancer, in a total of

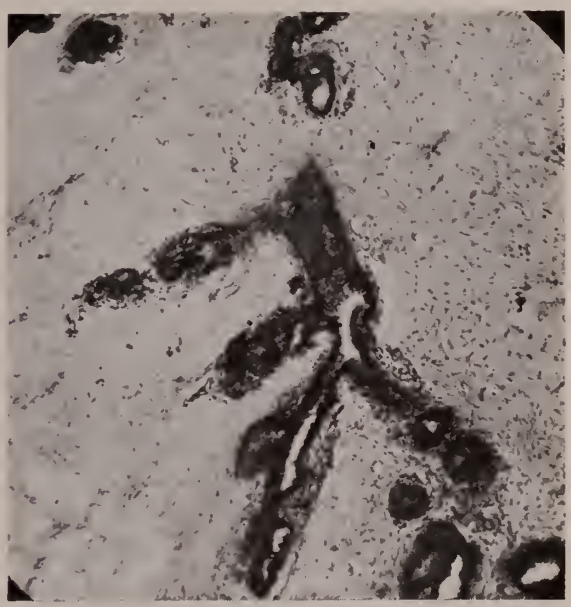


Figure 6. Photomicrograph of surgical specimen showing fibro-adenoma with marked cellular proliferation; x 300.

1722 verified cases of neoplastic disease of the breast in the Barnard Free Skin and Cancer Hospital of St. Louis. Of all the breast tumors 2.5 per cent were in the male, and 0.87 per cent of all male and female breast cancers were in the male. The youngest male patient was 42 and the oldest 75 years. The age distribution, based on crude figures, was 59.5 years. Of considerable interest is the significant history of trauma in 26.7 per cent of his cases. Three writers, Wainwright, Behan[10] and Gilbert have found trauma is sufficiently frequent to be

considered as a predisposing factor of the disease.

Verified axillary metastases were found in 80 per cent of Peck's cases by the time they received treatment. This is almost twice that recorded by Sachs. However, as Peck observes, one must take into consideration such variables as the size of the lesion, ulceration, duration of the disease and grade of malignancy when correlating any two sets of statistics.

SUMMARY

A case of adenocarcinoma of the breast with a significant history of repeated trauma is reported in a male, 59 years old. No metastases were verified at the time the patient began treatment which consisted of radical mastectomy, followed by x-ray therapy. The patient died of extensive carcinomatosis approximately two years after the beginning of treatment.

A brief review of the literature is included.

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Our ideas of sanatorium treatment are changing. Perhaps the most important change is the gradual realization of the influence of mental and emotional factors upon organic disease. For too many years, attention has been focused on the organ in which tuberculosis disease has developed, and physicians have ignored the fact that tuberculosis patients are also human beings. Contributing to this attitude has been the false assumption that tuberculous persons are always cheerful, happy, and hopeful of the future. Ann'l Rep't, Cattaraugus Co. (N. Y.) Health Dept., 1944.

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From a village newspaper: "Due to the shortage of paper, a number of births will be postponed until next week."

## N. Y. STATE MEDICAL SOCIETY URGES ESTABLISHMENT OF COUNTY HEALTH DEPARTMENTS

The House of Delegates of the Medical Society of the State of New York has adopted a resolution urging the voluntary establishment and maintenance of county health departments throughout the State as a means of correcting existing deficiencies in public health administration. The considerations which motivated this action are recorded in the resolution which appears below:

WHEREAS, The Medical Society of the State of New York is cognizant of the limitations of public health service under part-time health organizations such as now exist in most townships, villages and small cities of the State, and

WHEREAS, The State of New York after January 1, 1947, through increased state financial assistance to counties will make it increasingly advantageous for counties to establish and maintain modern health services by organizing a county health department staffed by full-time professionally trained medical and auxiliary personnel on a merit system basis and at the same time permit the retention of local part-time health officers able to demonstrate their value as a part of a county-wide organization, and

WHEREAS, This Society approved on May 9, 1927, the county health department form of organization and subsequently reaffirmed said approval, and

WHEREAS, The House of Delegates of the American Medical Association on June 10, 1942, passed a resolution urging the establishment of full-time modern health services to provide complete coverage of the nation's area and population,

BE IT RESOLVED, That the House of Delegates of the Medical Society of the State of New York urge the voluntary establishment and maintenance of county health departments throughout the State at the earliest possible date in order that the existing deficiency in public health administration be corrected, and

BE IT FURTHER RESOLVED, That a copy of this resolution be sent to the Honorable Thomas E. Dewey, Governor of the State of New York, and to the Honorable Edward S. Godfrey, Jr., M.D., Commissioner of Health of the State of New York.

## BENZEDRINE PREVENTS CONDITION DUE TO SLEEPING PILL POISONING

### Doctors Say If Patient Does Not Receive Immediate Treatment Complications Will Occur Leading To Death

Benzedrine, a drug used in the treatment of certain depressive conditions such as that produced by alcoholism, has been newly applied in the treatment of sleeping pill poisoning and proved to be highly successful, according to two doctors writing in the June 22 issue of *The Journal of the American Medical Association.*

The doctors—A. W. Freireich and J. W. Landsberg of Hempstead, N. Y.—treated 14 patients with poisoning from sleeping pills by giving them injections of benzedrine into the veins. Thirteen patients recovered completely except for a slight headache. The one patient who died had not received, in the authors' estimation, a sufficient quantity of the drug because it was not available.

The patients treated by Drs. Friereich and Landsberg were all admitted to Meadowbrook Hospital (Nassau County, N. Y.) in coma from an overdosage of sleeping pills taken with suicidal intent.

The symptoms in a typical case of poisoning with barbiturates are extreme depression of the central nervous system with coma, shallow breathing and low blood pressure falling rapidly to shock levels. The need for active and persistent treatment of sleeping pill poisoning cannot be stressed too strongly, the authors say. A false sense of security is felt on observing the state of coma. Unless a noticeable blueness of the skin with cycles of increased and decreased respiration or elevation of temperature has developed in addition to the other symptoms, the usual impression is that the patient is merely in a deep sleep and will awaken after the effects of the drug have worn off. Valuable time may be lost if active treatment is not undertaken rapidly for death will occur from respiratory depression, bronchopneumonia or partial collapse of the lungs.

Picrotoxin has been a widely used drug in the treatment of this type of poisoning because it is a powerful stimulant of the nervous system. However, the authors felt that it was too dangerous because it commonly led to convulsions while the patient was still in a deep coma. As an example the authors cite the fact that in a series of 24 cases of sleeping pill poisoning in which the patients were treated with picrotoxin, five deaths occurred.

In conclusion the authors state: "The evaluation of any drug in barbiturate intoxication is very difficult, the individual response to different does is so variable. No doubt some of the patients, if undisturbed, might have had a long sleep and awakened none the worse for their experience. However, the need for active treatment to prevent pulmonary stasis, congestion, pneumonia and atelectasis is always present. The shallow respiration of the person in deep sleep makes him a potential candidate for these pulmonary complications, and shortening the period of sleep, even though it may not be treatment essential to preserve life, is desirable."

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Mass surveys of chests with x-rays often find, but do not necessarily identify, disease. Editorial, The Ohio State Medical Journal, April, 1946.

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The general hospital plays a very important role in the organization for the fight against tuberculosis inasmuch as it offers facilities necessary to tie together the agents of research, prevention and treatment. But many general hospitals refuse admission to patients afflicted with pulmonary tuberculosis and many insist upon the removal of patients whenever diagnostic study discloses the presence of this disease. Public health education has accomplished much by way of removing the barriers of prejudice which formerly restrained general hospitals from accepting tuberculosis patients and modern methods in the control of infection have made possible a certain degree of intercommunication among patients with various types of illness without danger of cross-infection. Consequently, it is entirely feasible for general hospitals knowingly to accept for treatment patients suffering from pulmonary tuberculosis. Hospital Survey News Letter, Feb., 1946.

# News of the State

## PERSONALS · COMING EVENTS · MARRIAGES · DEATHS

### ALEXANDER COUNTY

A clinic for crippled children sponsored by the Alexander-Pulaski County Medical Society, County Health Department and the American Legion Auxiliary was held at St. Mary's hospital, Cairo, on July 11th.

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Dr. Charles Yarbrough, formerly of the resident staff of St. Louis Hospital, St. Louis, has begun practice in Cairo. He will be associated with Doctors Flint Bondurant and Fay S. Comer. Dr. Yarbrough served three years in the hospital corps of the United States as a captain.

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### CHAMPAIGN COUNTY

Dr. C. S. Bucher, president of the Champaign County Medical Society, has been named general chairman of Burnham City hospital's $700,000 drive for the erection of a new addition.

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Col. William H. Schowengerdt, of Champaign, addressed the Champaign Chapter of the Reserve Officers Association on July 1st. He discussed his five years of army service in World War II, particularly as commanding officer of the hospital ship, Marigold.

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### COLES COUNTY

Dr. John R. Alexander, recently discharged from the Army Medical Corps after having served since December 24, 1942, has re-opened offices in Charleston and will continue civilian practice of medicine.

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### COOK COUNTY

Three Chicago physicians took part in the program of the National Gastroenterological Association held in New York in June. Dr. M. Herbert Barker talked on "Acute and Chronic Gastrointestinal Manifestation of Infectious Hepatitis." Dr. Sidney A. Portis discussed "Gastroenterological Aspects of Psychosomatic Medicine" and Dr. Max Thorek talked on "Surgical Aspects of Cholecystitis."

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Comdr. M. H. Jones, Chicago, has returned to civilian medical practice after four years service in the Medical Corps of the United States Navy.

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Dr. Eric Oppenheimer has resumed his practice of medicine in Chicago after service in the Army Medical Corps.

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Dr. Hugo Stanka, 903 W. Garfield Boulevard, Chicago, has been elected chairman of the Chicago South Side Auxiliary Committee, American Relief to Austria. Anyone interested in being of assistance in these activities can get in touch with Doctor Stanka at his home address. He has asked that physicians contribute their sample drugs and any other excess material they may have on hand.

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Dr. Warren W. Furey, Chicago, has been elected treasurer of the American College of Radiology.

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Dr. Fremont A. Chandler, professor of orthopedic surgery and director of the Illinois Surgical Institute for Children, University of Illinois, was elected chairman of the general medical advisory committee for the Cook County chapter, National Foundation for Infantile Paralysis.

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Dr. Ole C. Nelson, medical director of the Cook County Hospital, was guest of honor at a dinner at the Congress Hotel, June 20, given by more than one hundred friends and associates in recognition of his completion of thirty-five years' service to the hospital. Dr. Nelson has been medical director for ten years.

Dr. Andrew C. Ivy, since 1925 Nathan Smith Davis professor of physiology and pharmacology and head of the division of physiology and pharmacology, Northwestern University Medical School, has been appointed vice president in charge of the Chicago Professional Colleges of the University of Illinois and distinguished professor of physiology in the graduate school, effective September 1. Succeeding Dr. Raymond B. Allen, who recently resigned as executive dean of the Chicago colleges to become president of the University of Washington, September 1, Dr. Ivy will be chief administrator of the university's colleges of medicine, dentistry and pharmacy and its hospitals and institutes. The office of vice president in charge of the Chicago Professional Colleges is a newly created position, the first vice presidency in the university organization. Dr. Ivy graduated at Rush Medical College in 1922. During the war he was director of the Naval Medical Research Institute, Bethesda, Md., as well as consultant to the Bureau of Medicine and Surgery of the Navy, the Nutrition Laboratory of the Office of the Surgeon General of the Army and the planning division of the Quartermaster General of the Army.

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Dr. William W. Scott, associate professor of surgery (urology), has been named director of the Brady Urological Institute and professor and head of the department of urology at Johns Hopkins University School of Medicine, Baltimore. The appointment fills the vacancy that occurred when Dr. Hugh H. Young, founder of the Brady institute, died on Aug. 23, 1945.

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Dr. Harold R. Hennessy, assistant secretary, Council on Industrial Health, American Medical Association, was recently admitted to knighthood in the Order of Orange-Nassau, degree of Officer with Swords. The honor was conferred by Queen Wilhelmina of the Netherlands.

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Dr. Harold H. Steinberg has been elected chairman of the Chicago section of the American Industrial Hygiene Association.

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Dr. Albert H. Montgomery, who has retired as chief of the surgical department of the Children's Memorial Hospital after twenty-five years' service, was given a dinner at the Swedish Club, June 21, by the hospital's Alumni Association.

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At the annual meeting of the American Medical Association in San Francisco, Dr. Frederick H. Falls, University of Illinois College of Medicine, was presented with the silver medal for teaching for his exhibits on poisons in pregnancies.

Dr. Anton J. Carlson, emeritus professor of physiology at the University of Chicago, was chosen by the house of delegates of the American Medical Association, to receive the organization's 1946 distinguished service medal.

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Dr. Charles Eiseman of Northbrook, who served in the navy for the past 18 months, has recently been released and is resuming the practice of medicine in Winnetka and Chicago.

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Dr. Pliny R. Blodgett is back in Chicago Heights following his release from the navy. A veteran of both world wars, Dr. Blodgett served in both the army and navy. In his recent duty, he was first surgeon aboard a transport plying between this country and Europe.

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The U. S. Public Health Service has approved grants-in-aid totaling about $50,000 for cancer research at eight universities. The allotments include: Loyola University, Chicago, $2,847, and Northwestern University, $2,500.

The agency said the National Advisory Cancer Council has recommended that Surgeon General Thomas Parran call a conference on gastric cancer at the University of Chicago late this fall.

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Appointment of 74 civilian surgeons and physicians as consultants to the Secretary of War has been announced by Major General Norman T. Kirk. All are specialists and most served as Medical Corps officers during World War II. They will undertake to observe and "improve wherever possible the quality of medical care given the American soldier."

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The Educational Committee arranged a series of lectures which were given in August at the Museum of Science and Industry, Chicago. The speakers were Doctors W. W. Bauer who talked on "The Nation's Health Is Good", Edward A. Piszczek who discussed "Infantile Paralysis", Robert S. Berghoff who talked on "Coronary Disease" and Herbert E. Schmitz who talked on the subject of "What We Are Doing About Cancer."

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The University of Chicago and Northwestern University schools of medicine have been named by the National Foundation for Infantile Paralysis as among the 28 institutions awarded grants during the current year for research and education in the field of poliomyelitis. The University of Chicago will receive $6,685, and Northwestern University, $5,000.

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An informal dinner was held at the Palmer House, June 22, honoring Dr. and Mrs. Raymond B. Allen. A portrait medallion of Dr.

Allen, executive dean, Chicago colleges of the University of Illinois and dean of the medical school, was unveiled and presented to Arthur C. Willard, LL.D., Urbana, Ill., president of the university. Dr. Allen has announced his resignation to become president of the University of Washington, Seattle.

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A workshop in health education opened at the Southern Illinois Normal University, June 10, to continue until August 3 and one at the Illinois State Normal University, June 29, to continue until August 23. The workshops permit the participants to develop specific projects based on their own teaching experience and, by comparisons and discussions, stimulate interest regarding the health of the whole child, the whole school and the whole community.

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Dr. James J. Smith, former director of physiology for the 8th Air Force medical establishment, has been named dean of the Loyola University Medical School. Prior to entering the service, he was a member of the faculty of Northwestern University Medical School.

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*The Carl Hedblom Lecture.*—Dr. Cameron Haight, professor of surgery, University of Michigan Medical School, Ann Arbor, recently delivered the eighth Carl Hedblom Lecture at the University of Illinois College of Medicine, on "Congenital Atresia of the Esophagus with Tracheo-Esophageal Fistula." The lectureship, sponsored by Iota chapter of Phi Beta Pi Fraternity, perpetuates the memory of the late Dr. Carl A. Hedblom.

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*Personal.*—Mr. Charles E. Nyberg, since 1938 an associate in the Bureau of Medical Economics of the American Medical Association, has resigned to become assistant to the executive secretary of the American College of Radiology, effective June 30. Since Mr. Nyberg returned from three years' service in the navy, he has been in temporary charge of the Bureau of Medical Economics and collaborating with the staff of the Council on Medical Service and Public Relations. Mr. Nyberg was released from the service with the rank of lieutenant, U.S.N.R.

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*Grant to Hektoen Institute.*—The biochemical division of the Interchemical Corporation has given an annual grant of $25,000 to the Hektoen Institute for Medical Research of the Cook County Hospital for the establishment of a metabolic unit to perform nitrogen balance studies on various amino acid preparations.

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*David Shakow Joins Illinois Staff.*—David Shakow, Ph.D., chief psychologist, Worcester State Hospital, Worcester, Mass., for eighteen years, has been appointed chief psychologist in the psychiatric division of the Illinois Neuropsychiatric Institute and professor of psychiatry at the University of Illinois College of Medicine. The new appointment will be effective September 1.

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*Special Society Elections.*—The Chicago Pediatric Society announces as officers for the coming year, Dr. Joseph Greengard, president; Dr. H. William Elghammer, vice president; Dr. Alvah L. Newcomb, Winnetka, Ill., secretary, and Dr. Craig D. Butler, Oak Park, Ill., treasurer.—Dr. Aaron E. Kanter was chosen president-elect of the Chicago Gynaecological Society at its meeting June 21. Dr. Ralph A. Reis was installed as president. Other officers include Dr. Eugene A. Edwards, vice president, Dr. Magnus P. Urnes, treasurer, and Dr. Herbert E. Schmitz, secretary.—At the annual meeting of the Chicago Society of Internal Medicine Dr. Laurence E. Hines was elected president, Dr. Henry T. Ricketts, vice president and Dr. Richard B. Capps, secretary-treasurer.

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*University of Chicago Medical Alumni.*—The second annual meeting of the Alumni Association of the University of Chicago School of Medicine was held at the Albert Merritt Billings Hospital, June 10, under the presidency of Dr. Victor E. Johnson. The scientific program consisted of the following:

Drs. Peter V. Moulder Jr. and Charles B. Huggins, Estrogen Production by Sertoli Cell Tumors of the Testis.

Drs. Edward H. Storer and Lester R. Dragstedt, Vagus Section for Peptic Ulcer.

Drs. John D. Arnold, John H. Edgcomb and Alexander Brunschwig, Sulhydryl Stimulation and Inhibition of Tumor Growth.

Dr. Leon O. Jacobson, Effects of Nitrogen Mustard on Neoplastic Diseases of Blood Forming Tissues.

Drs. Howard W. Owen, Edward H. Senz and Hilger P. Jenkins, Control of Hemorrhage from the Great Vessels and the Heart by Gelatin Sponge.

New officers chosen at the meeting include Dr. Hilger P. Jenkins president, Dr. William C. Drennan vice president, Dr. William B. Tucker secretary and Dr. James R. Wilson treasurer. It was decided that the quarterly alumni bulletin would be expanded, with the greatest emphasis to be placed on the scientific section. Dr. William H. T. Murray was appointed editor to succeed the retiring editor, Dr. Francis B. Gordon.

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## DUPAGE COUNTY

Dr. A. R. Rikli of Naperville addressed the Lisle Woman's Club on July 2nd speaking on the subject, "Medical Care of the School Child."

GREENE COUNTY

Dr. J. A. Cravens of Greenfield, was an honored guest at a recent meeting of the Morgan County Medical Society. Dr. Cravens had completed 50 years in the practice of medicine. Dinner was served at the Dunlap Hotel, Jacksonville, followed by a program. Dr. Stanley Gibson, Chicago, spoke on "Rheumatic Fever." Dr. Walter Stevenson of Quincy, councilor of the sixth district and chairman of the Council of the Illinois State Medical Society, was master of ceremonies for the Fifty Year Club induction.

KANE COUNTY

Dr. Robert H. Sykes has announced the establishment of an office for the practice of pediatric medicine in the Geneva Clinic. Dr. Sykes served 4 years in the army medical corps.

LAKE COUNTY

Dr. John L. Ward, recently discharged from the navy after three and a half years service, has started civilian practice in Lake Bluff.

LASALLE COUNTY

Dr. A. J. Roberts, Ottawa, long prominent in fraternal circles has been elected "great medical examiner" for the Illinois Lodge of Maccabees.

LEE COUNTY

Dr. Horace Dunn has moved his family to Franklin Grove where he will practice medicine and surgery. Dr. Dunn was located in Ladd and Granville for 30 years where he was company physician for the Milwaukee railroad.

LIVINGSTON COUNTY

Dr. O. L. Bettag, Pontiac, president of the Livingston County Medical Society, has announced that the society is cooperating with the Illinois State Medical Society and the American Cancer Society. A county cancer control committee has been appointed and consists of Dr. E. F. Joss, Dwight, chairman, Dr. H. L. Lockner, Chatsworth, Dr. Carl Ward, Pontiac.

Members of the Livingston County Medical Society were guests of doctors from Fairbury, Forrest, Chatsworth and Piper City at a dinner meeting in July at the home of Dr. H. C. Sauer, Fairbury. Other hosts were Doctors H. L. Langstaff, Sr. and Jr., W. A. Marshall, G. G. Seitman, H. L. Lockner and C. E. Branch. Dr. Fremont Chandler, Chicago, presented the scientific program speaking on "Low Back Pain."

McLEAN COUNTY

Dr. John W. Turner of Kankakee has been appointed the new director of the McLean County Health Unit. Dr. Ralph Peairs, president of the county health board, has announced that the new McLean County Health Department will absorb the 66 year old city health office.

Dr. George W. France, formerly of Chicago, has opened an office in LeRoy for the practice of medicine. Dr. France served two and one-half years in the army medical corp, 14 months of the time in seven countries in Europe.

MACON COUNTY

Dr. W. L. Terrell has opened an office in Maroa for the practice of medicine. His last assignment in his three years' service in the army was medical officer in charge of a 600 bed prisoner of war hospital in Germany.

MADISON COUNTY

Members of the Madison County Medical Society met at Beverly Farms on July 3rd as guests of Dr. Groves B. Smith, Dr. Leland Smith and their mother, Mrs. W. H. C. Smith. After the dinner and a business session, a fireworks display was given.

MOULTRIE COUNTY

Dr. Grover C. Chamness, formerly of Ottawa, has opened a practice in Lovington which has been without a resident physician since the war.

OGLE COUNTY

Dr. Sherwood Baker, who was released from the army medical corps, has recently become associated with Dr. M. S. Dumont in the practice of medicine at Mt. Morris.

PEORIA COUNTY

Dr. Clinton S. M. Koerner, native Peorian, discharged by the army after 22 months of overseas service as battalion surgeon in the medical corps, has resumed his civilian practice in Peoria.

Dr. Richard J. Graff is the new superintendent of Peoria State hospital. Dr. Graff returned recently from military service in which he spent three and one-half years, two of them overseas with Ninth Air Force hospitals.

ROCK ISLAND COUNTY

Dr. John H. Fowler who has practiced medicine in East Moline for the last thirty years has retired and gone to live on his farm in southern Missouri.

SAINT CLAIR COUNTY

Dr. Carroll F. Leonard has been appointed Director of the East St. Louis Health District.

Dr. Cldye S. Wilson, of Belleville, has been appointed chief medical officer for the newly organized medical division in the Veterans Administration subregional office, East St. Louis.

## SANGAMON COUNTY

Opal C. Hartline, Ph.D., Ashley, has been appointed chief of public health education in the Illinois State Department of Public Health, Springfield, to succeed Miss Jean Christopher, M.Ph., who has resigned.

## TAZEWELL COUNTY

Dr. Arnold H. Claycomb, who practiced medicine in Minonk before entering the army, received his discharge after serving 42 months and he will practice medicine and surgery at Pekin with Dr. W. S. Needham.

## WINNEBAGO COUNTY

Dr. William H. Palmer has opened offices in Rockford where he will specialize in treatment of rectal and colon diseases. Dr. Palmer was the first Rockford physician to serve overseas in World War II. He spent four and one-half years in the service.

## DEATHS

Raymond E. Bechtel, Chicago; Northwestern University Medical School, 1908. Was examining physician for the Illinois Central Railroad for the past 15 years. Died July 5th, aged 60.

Celsus Elliott Beguesse, Chicago; University of Illinois College of Medicine, 1943. Began active duty in the army medical corps, July, 1945; on the staff of the Veterans Administration Facility in Tuskegee, Ala.; killed near Tuskegee, May 13th, aged 30, in the crash of a B-29 bomber.

Henry Bernardus de Bey, Kewanee; Rush Medical College, 1889. Died March 9th, aged 84, of secondary carcinomatosis.

Harry David Ellis, Champaign; University of Illinois College of Medicine, 1928; served during World War I. Died April 16th, aged 50.

Mortimer E. Emrick, Chicago; Northwestern University Medical School, 1904. Practiced medicine on the south side for 40 years. Died July 6th, aged 69.

Cloyde Reber Fisher, Decatur; University of Chicago School of Medicine, 1935. Died in the Macon County Hospital March 8, aged 49, of carcinoma of the lung.

Lars A. Garness, retired, Chicago; Chicago College of Medicine & Surgery, 1916. Formerly president of the medical staff of the Norwegian-American hospital. Died July 15, aged 63.

Charles Willard Geiger, Kankakee; Chicago Homeopathic Medical College, 1896. Specialized in eye, ear, nose & throat for more than 40 years in Kankakee. Was member of the Kankakee County Tuberculosis Sanatorium Commission; past president of the Chamber of Commerce and Rotary Club of Kankakee. Died July 19th, aged 75.

Carl Bertram Hall, Wilmette; Northwestern University Medical School, 1937. Served in the army medical corps since Sept., 1942, serving in China and India. Died at Camp Kilmer, N. J., January 4th, aged 34, of hepatitis.

Marion E. Lamke Holliday, Wilmington; Hahnemann Medical College and Hospital, 1894. Died March 14th, aged 79.

Howard Lee Isenberg, Wyoming; University of Illinois College of Medicine, 1943. Served in the army medical corps since Feb., 1944; relieved from active duty in Dec., 1945; died Feb. 1, aged 27, of injuries received in an automobile accident while on terminal leave which was to end February 5th.

Peter J. McDermott, Kewanee; State University of Iowa College of Medicine, 1904. Was secretary of Henry County Medical Society for many years. Died July 7th at the age of 74.

Robert Bruce Malcolm, Chicago; McGill University, Montreal; 1910. Associate professor of surgery at University of Illinois College of Medicine. Died of a heart attack, June 22nd, while making his rounds at Illinois Masonic Hospital. He was 57 years old.

James Murney Nicholson, Chicago; Rush Medical College, 1900. Had practiced medicine in the Edgewater district since 1902. Died June 23rd, aged 69.

Samuel D. Nixon, Chicago; Rush Medical College, 1904. South side physician for 42 years. Died July 2nd in Englewood hospital, aged 74.

Charles C. O'Byrne, Chicago; University of Illinois College of Physicians & Surgeons, 1894. Formerly associate professor of pathology at the University of Illinois College of Medicine. Died in his home, July 10th, aged 77.

Paul George Papsdorf, Chicago; Chicago Medical School, 1922, Chicago College of Dental Surgery, 1915. Was instructor in oral surgery and oral surgeon, Evangelical hospital. Died in Little Company of Mary hospital June 21st after being found the day before in a pool of water in a forest preserve. He was 55.

James A. Price, Chicago; Chicago Medical School, 1937. Died February 10th, aged 40, of pulmonary tuberculosis with Pott's disease of the spine.

Joseph Romano, Congress Park; Loyola University Medical School. Practiced in Chicago for 30 years. Died recently, aged 70.

David H. Stern, Calumet City; University of Illinois College of Medicine, 1937. Served almost 3 years with the army air forces as a medical officer, serving 18 months in Africa, Sicily and Italy. Died in his home, July 14th, following a heart attack. He was 38 years of age.

Otto F. Warning, Chicago; Jenner Medical College, 1905. Died in his home June 14th, aged 72.

Clifford V. Winsett, Brookfield; University of Illinois College of Medicine, 1905. Died of a heart attack June 13th in the Soldiers' and Sailors' Home in Quincy where he had come three days previously to take a position as house physician. He was 60 years old.

# FACTS ABOUT THE PREPARATION OF



## Campbell's STRAINED BABY SOUPS

***Q. How are meats prepared for the soups?***

*A.* The full protein and other nutritive values in meat are available only when the meat solids as well as the juices of meat are used. Campbell's method of comminuting the meat—superior to the "scraping" common in home use—assures that all the edible solids as well as all the juices are included. Four of the Campbell's Strained Baby Soups have a meat base: Chicken, Liver, Lamb and Beef.

***Q. How early may these soups be started?***

*A.* That depends entirely upon the individual baby and the physician's judgment. However, these soups are intended for use as early as any strained baby food. The soups are not seasoned (except for light salting) and are of smooth texture and uniform consistency. A comprehensive analysis of each soup may be had upon request to Campbell Soup Company, Camden, New Jersey.

***Q. How are vegetables prepared for the soups?***

*A.* Both the flavor and the nutritive values of vegetables naturally depend in great part upon the way they are handled and cooked. Campbell's have developed a method, based on the latest scientific knowledge, which retains the minerals and efficiently conserves the vitamins, as well as the wholesome natural flavors.

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*VEGETABLE*

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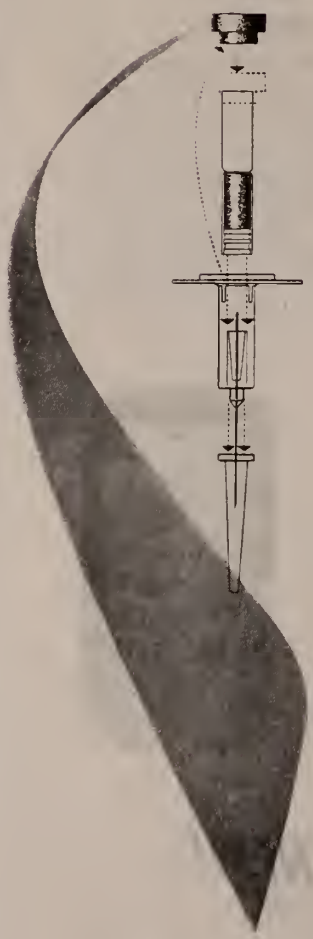

Campbell's Strained Baby Soups represent fine quality . . . in ingredients . . . in care and method of cooking . . . in retention of minerals and conservation of vitamins . . . *and in good flavor.* Every resource of Campbell's Kitchens is devoted to that aim.




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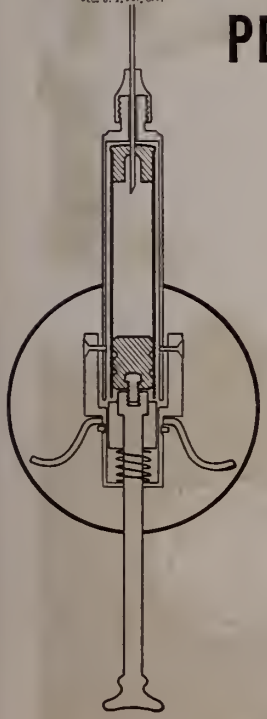
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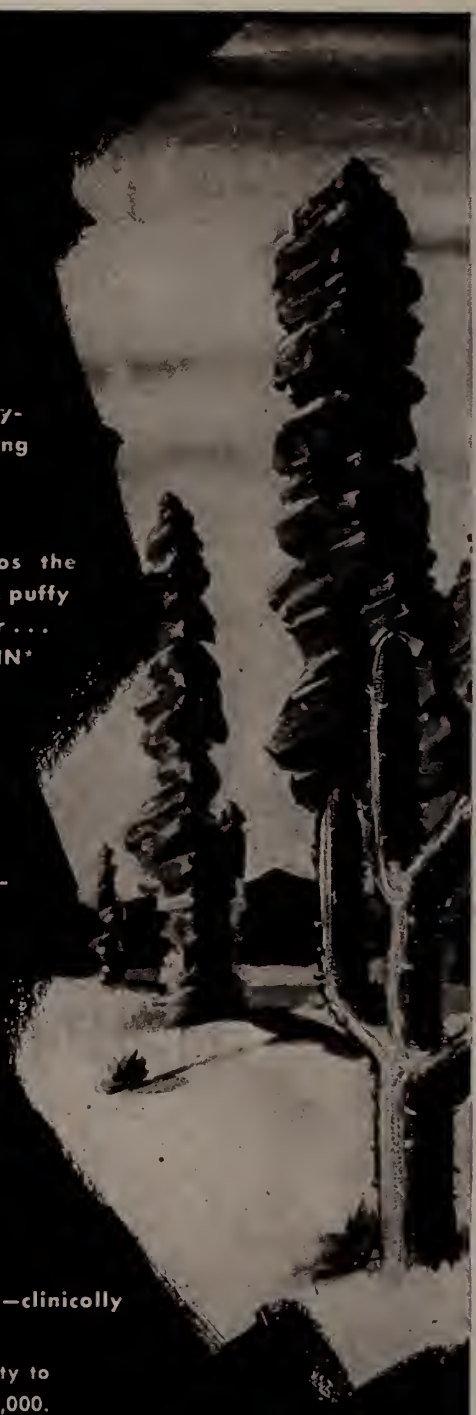
- Most cases of gonorrhea are cleared up by a single injection.
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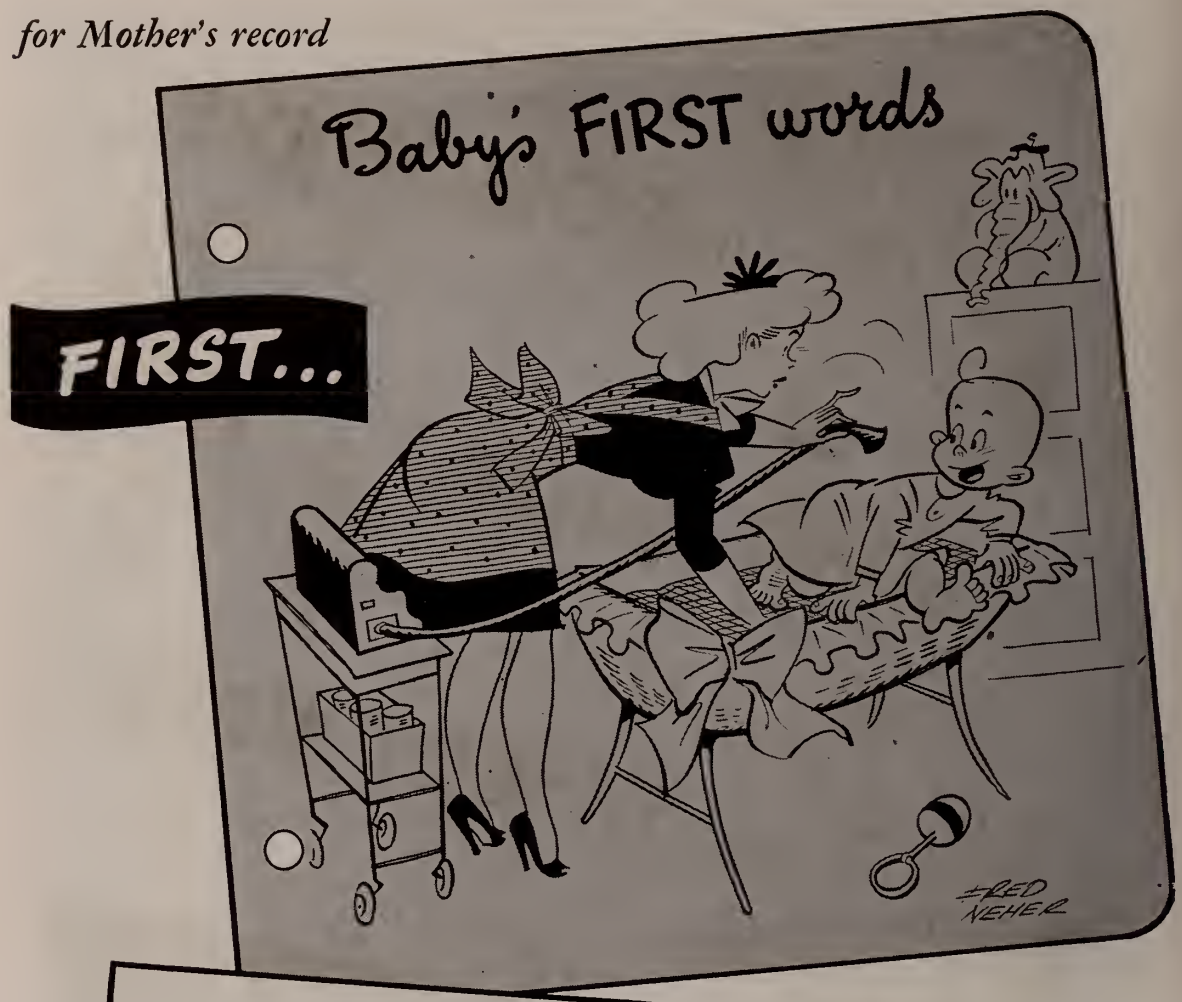
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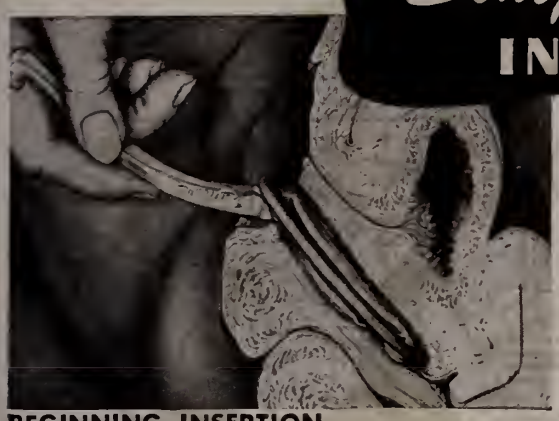

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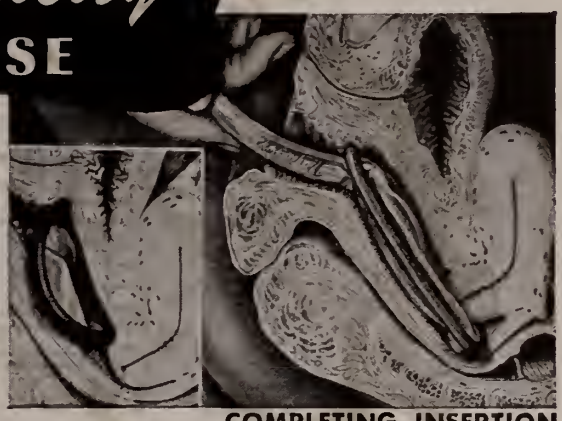
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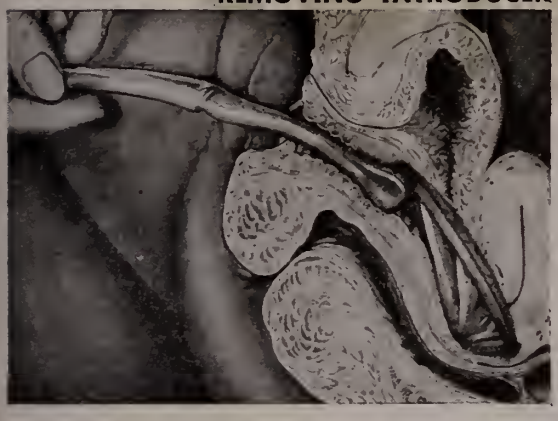


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These illustrations, showing the simplicity of use of "RAMSES" Gynecological Products, are reproduced from the booklet *Instructions for Patients.* For the physician's convenience, a supply of these booklets is available, upon request, for distribution to patients.

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Hastily consumed meals, factory whistles, and the insistent challenge of the time clock — such is the background of functional digestive disturbances among many office and factory workers.

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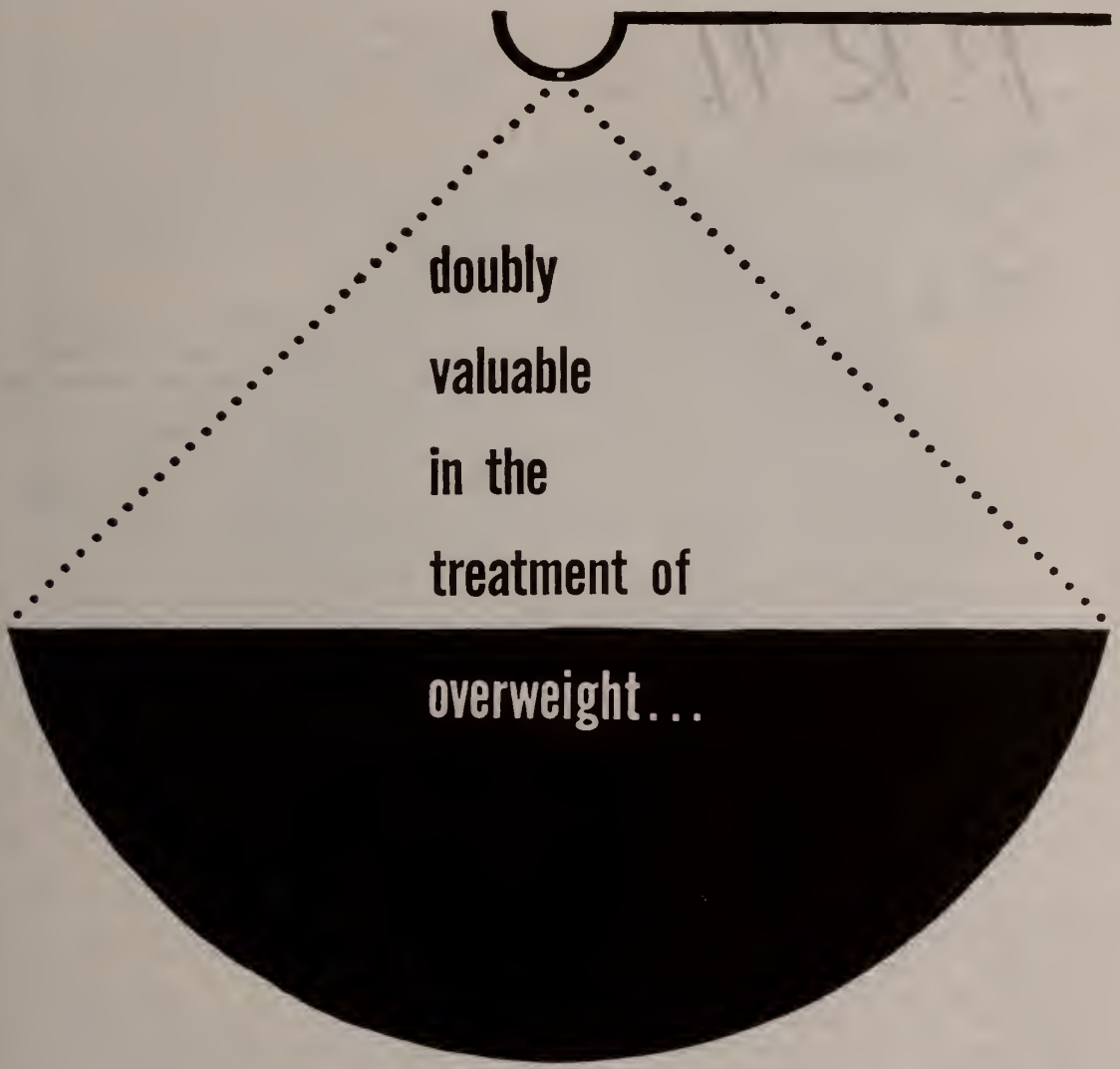
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***Dosage:*** 2 to 8 tablets with each meal and at bedtime.

***Available:*** Bottles of 25, 100, 500 and 1000.

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In a recent clinical study, Hawirko and Sprague* found that *Dexedrine* (*d*-amphetamine) exerts two beneficial actions in the treatment of overweight:

1. It depresses the appetite "sufficiently to enable the patient to follow the diet closely without feeling it too great a burden".

2. Its unique central nervous stimulant effect combats the feeling of "discouragement and irritability which usually accompanies rigid adherence to prolonged use of a low calorie diet".

*Canad. M. A. J. 54:26 (Jan.) 1946

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(dextro-amphetamine sulfate, S.K.F.)

Smith, Kline & French Laboratories, *Philadelphia*

# P. R. N.

The Jocular Jingles of C. G. F.

by

Charles G. Farnum M. D.
Peoria, Ill.

## ALLERGICS

'Tis the last half of August, there comes with each breeze
All the dusts and the pollens that cause us to sneeze;
And our noses are leaking, our eyes are all red,
While an aching and throbbing traverses our head.

When we try to eat food the stuff tastes all the same,
And the thing we call smell is there only in name;
We cannot sleep nights as we cough and we blow,
And we ache from the crown of our head to each toe.

So from now 'til it freezes we're victims of fate.
We're exhausted until we can scarce navigate.
As allergics, a sensitized human receiver,
But our outstanding grief is this awful hay fever.

Pathological Sonnet

## CHIGGERS

**Beneath a leafy bower in bosky dell**
**We spent a peaceful Sabbath afternoon,**
**We ate our lunch where only wood-nymphs dwell**
**And lingered long to watch the rising moon.**
**That night came big red blotches we detest,**
**In countless numbers from our chest to toes,**
**And each one itched and burned beyond the rest**
**Precluding sleep; one could not even doze.**
**For days we rubbed and scratched and dug,**
**Did little else than twist and writhe and squirm,**
**And roundly cursed each parasitic bug**
**That lay beneath our burning epiderm.**
**Some modes of torture may perhaps be bigger,**
**But none for sheer distress surpass the chigger.**

## MY GARDEN OF CONTEMPLATION

I sit in my Garden of Contemplation,
With flowers and shrubs and green trees;
I lose my small self in deep meditation,
Caressed by a zephery breeze.

I meditate on the vastness of space,
And the nearness of vicious bees;
The ultimate fate of our human race,
And the habits and traits of fleas.

I meditate on the mission of man,
And the chiggers deep in my hide;
On all the world's most inscrutable plan,
The mosquitoes on every side.

I meditate on the future of life,
As the flies on my bald head prance;
The ceaselessness of our struggle and strife,
And the numberless bugs and ants.

I sit in my Garden of Contemplation,
With beautiful thoughts keenly logical,
But yet interrupted by molestation
From things that are entomological.

## HAY FEVER

**The summer flowers are blooming on the hills,**
**On roadsides grass and weeds have reached their prime;**
**The way said vegetation wholly fills**
**The atmosphere with pollen is a crime.**
**Therefrom my eyes become a firey red,**
**My weeping interspersed with vicious sneeze.**
**I have a leaky nose and aching head**
**From molds and pollens wafted by the breeze.**
**I cough without cessation through the night.**
**I weep and blow and wheeze. 'Tis worse than pain.**
**I hoped desensitizing hypos might**
**Bring some relief. The hope was all in vain.**
**The most effective treatment is to pray**
**For killing frosts to freeze the thing away.**

## THE QUETICO AT NIGHT

The tam'racks, pines and
balsams etch their lacy
silhouettes across the moon.
From up the lake there
comes the eerie, melancholy
cry of distant loon.

While tall and stately
arrow-headed spruce stand
guard like sentinels of peace,
The soft embracing stillness
brings from all our cares
and troubles prompt surcease.

The Northern Lights, like steam
from giant cauldrons, all
flare skyward bright and clear.
Though civ'lization now
seems very far away the
stars seem very near.

A shimmering streak comes
toward one o'er the gently
rippling waters sheen and glow;
The shore line's lost in
shadow and the wooded banks,
inverted, are reflected deep below.

This atmosphere of
restfulness and peace is
such, no matter where we go,
We cannot hope to
ever find a place quite
like the lovely Quetico.

THERE ARE "MANY ADVANTAGES" WITH PROGESTORAL THERAPY



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EFFECTIVE
SIMPLE · · ·
HARMLESS
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[1] F. E. Harding, Am. J. Obst. & Gynec., 50:56, 1945

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# Book Reviews

RENAL DISEASES, E. T. Bell. Lea & Febiger. Cloth. $7.00. Published 1946. Professor Pathology University of Minnesota.

This book primarily is for the pathologist — secondarily for the clinician — very scant consideration is given to Therapeutic. The author did not compile this work as a treatise on treatment, but as a guide to logical therapy based upon the pathological physiology presented by the patient.

Oft times the pathologist is unable to give an accurate diagnosis unless he also knows the clinical symptoms. The clinician many times fails in treatment because he has ignored the anatomical background of the disease.

This work aims to bring about closer cooperation between the man at the bedside and the man in the post mortem room. With this as his purpose the author classifies Renal Disease on an anatomical basis because the type of functional disturbance usually is closely related to the underlying structural alterations in the kidneys.

The role of the hormon, pitressin; oliguria and anuria; Edema, Glomerulonephritis; Preeclampsia and Eclampsia; Tubular diseases, degenerative and obstructive including poisons; Primary hypertension, the clinical forms of hypertensive disease; the effect of drugs on blood pressure; The influence of heredity on hypertension; Diabetes Mellitus; Disturbances of the Calcium metabolism, all the infections and new growths of kidney are considered at length.

In this way the rationale of treatment is presented — the details of any therapy become the problem of the physician himself.

It is a scholarly compilation of twenty-five years of research, study, and demonstrates clearly the striking parallel between anatomical changes as such, and the symptoms which must inevitably result from those changes in cellular structure. This is not a book to while away a rainy afternoon, but demands concentrated study. For the one who desires to visualize the CHANGES IN RENAL STRUCTURE in any given disease, to anticipate what further changes may supervene — and upon that foundation erects his house of therapy — the book is worth $7.00, and more. It was written by a student for those who wish to learn.

J.P.O.

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COSMETICS AND DERMATITIS, by Louis Schwartz, M.D., and Samuel M. Peck, M.D., of the U. S. Public Health Service. Published by Paul B. Hoeber, Inc.,

(*Continued on page 56*)

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* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
*Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60*

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**"These new radio-active drugs have me puzzled."**

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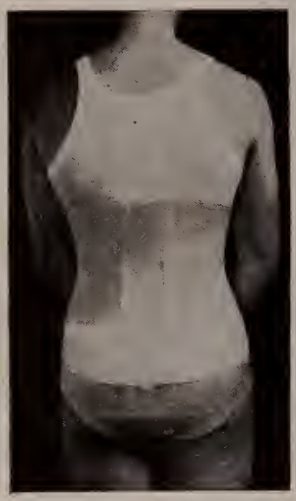
This free interchange of man's experience healing his fellow-man, this individual exploration into the vast field of medicine is an invaluable contribution to America. For America's progress is part and parcel of America's health. As in business or the arts, where independence begets initiative, so in Medicine the great advances come from the doctor's inner urge to improve, to discover, and to pass on to his colleagues everywhere the benefit of his findings.

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# A Spencer Spinal Support
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For Abdomen, Back and Breasts


## BOOK REVIEWS (Continued)

Medical Book Department of Harper & Brothers.

This is a book of 189 pages treating of the reactions of various cosmetics. They include some twenty pictures which are only fair in their reproduction, many of which do not show the dermatitis which is put in the caption. The antiquated method of blocking out the eyes in each of the pictures is unnecessary and it detracts even more from the idea which the pictures are supposed to portray.

In the text, however, the coverage is unusually complete. Their approach to the subject through the anatomy and physiology of the skin goes into considerable detail in a very acceptable manner. They show a very great comprehension of the chemistry of various appendages and excretions of the skin, and their treatment of all of these phases are according to the best accepted knowledge among dermatologists.

Their treatment of the allergic side of dermatoses is most commendable, accepting that there may be such a thing, we know that it has been much exaggerated in importance. They spare no effort in covering the acids and other chemical constituents of the cosmetics and their reaction both as a sensitizer and a primary irritant is complete. After going into considerable detail in a general way about these irritants, they devote a chapter to occupational dermatitis among barbers, hair dressers, beauticians, including the permanent wave, the cold wave, the reactions from lip stick, the fallacy of many advertisements regarding the beneficial results from vitamin creams and cream combined with the various endocrines and hormones.

Their coverage of dentifrices and deodorants, as well as their descriptions of hair bleaches and various natural and chemical dyes, and their evaluation of these preparations show that they still have their feet on the ground and are able to make a good assay of such processes.

Their warning regarding nail lacquers is timely. They devote one entire chapter to the methods of testing new cosmetics and if their suggestions regarding this is followed by the manufacturer we should have a marked lessening of such troublesome reactions. The book is well worth perusing even by the experienced dermatologist.

H.M.H.

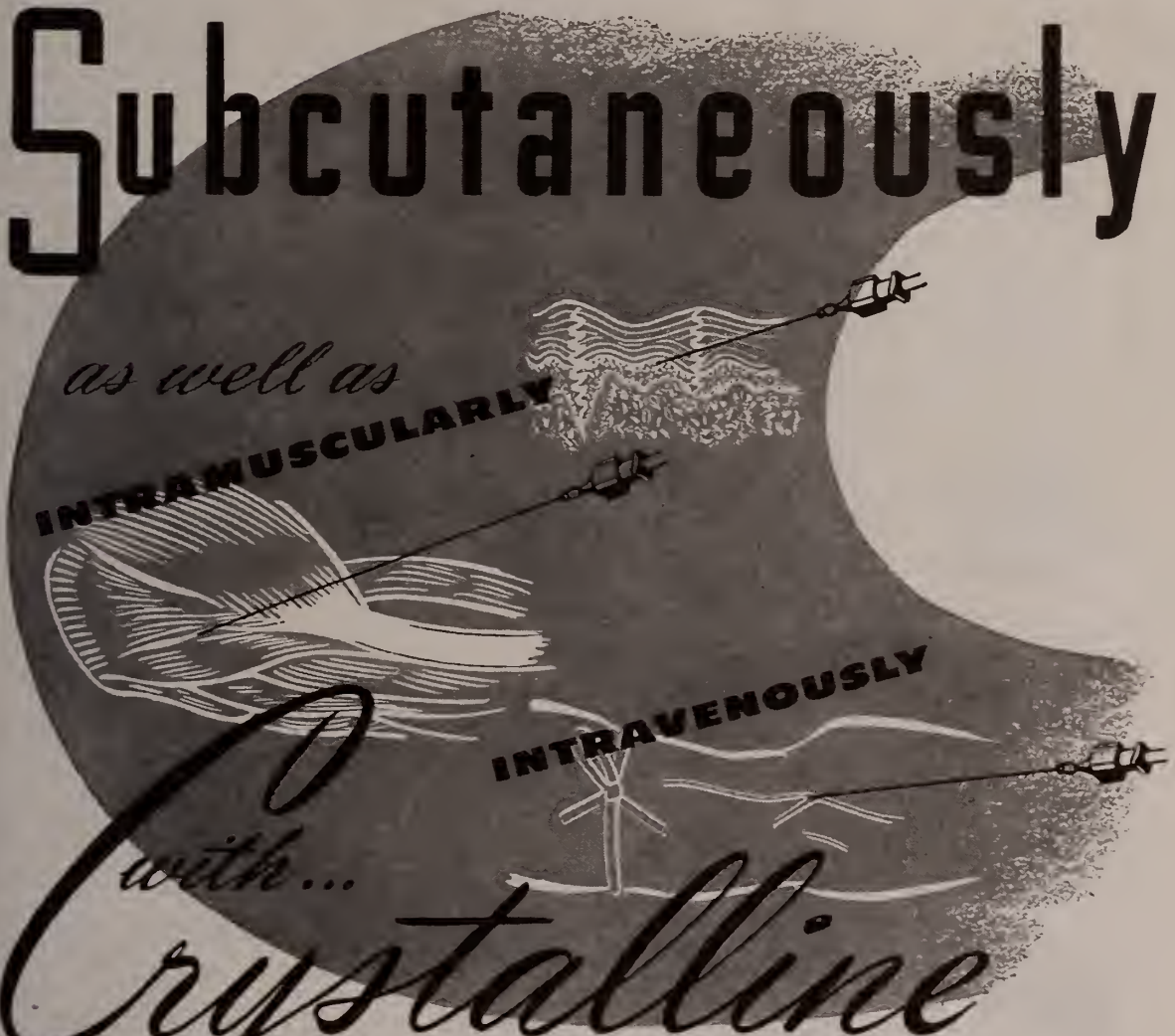
# Books Received

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

"AUTOPSY, DIAGNOSIS AND TECHNIC": By Otto Saphir, M.D., Pathologist, Michael Reese Hospital; Professor of Pathology, University of Illinois Medical School, Chicago. Foreword by Ludvig Hektoen, M.D., Second Edition, Revised and Enlarged. Il-

(*Continued on page* 58)

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lustrated. Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, New York. 1946. Price $5.00.

DISEASES OF THE RETINA: By Herman Elwyn, M.D., Senior Assistant Surgeon, New York Eye and Ear Infirmary. With 170 illustrations, 19 in color. Philadelphia, The Blakiston Company, 1946. Price $10.00.

DIABETES. A CONCISE PRESENTATION: By Henry J. John, M.A., M.D., F.A.C.P., Lt. Col., M.D., Cleveland, Ohio. Illustrated. St. Louis, The C. V. Mosby Company, 1946. Price $3.25.

WOMEN IN INDUSTRY, THEIR HEALTH AND EFFICIENCY: Issued under auspices of the Division of Medical Sciences and the Division of Engineering and Industrial Research of the National Research Council. Prepared in the Army Industrial Hygiene Laboratory by Anna M. Baetjer, Sc.D., Assistant Professor of Physiological Hygiene, School of Hygiene and Public Health, The Johns Hopkins Hospital, Philadelphia and London: W.B. Saunders Company, 1946. Price $4.00.

ANESTHESIA IN GENERAL PRACTICE: By Stuart C. Cullen, M.D., Head of Division of Anesthesiology, Department of Surgery, State University of Iowa Hospitals; Associate Professor of Surgery (Anesthesiology) State University of Iowa College of Medicine. The Year Book Publishers, Inc., Chicago. Price $3.50.





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1. Comroe, B. I.: Arthritis and Allied Conditions, Philadelphia, Lea & Febiger, 1944, p. 419.

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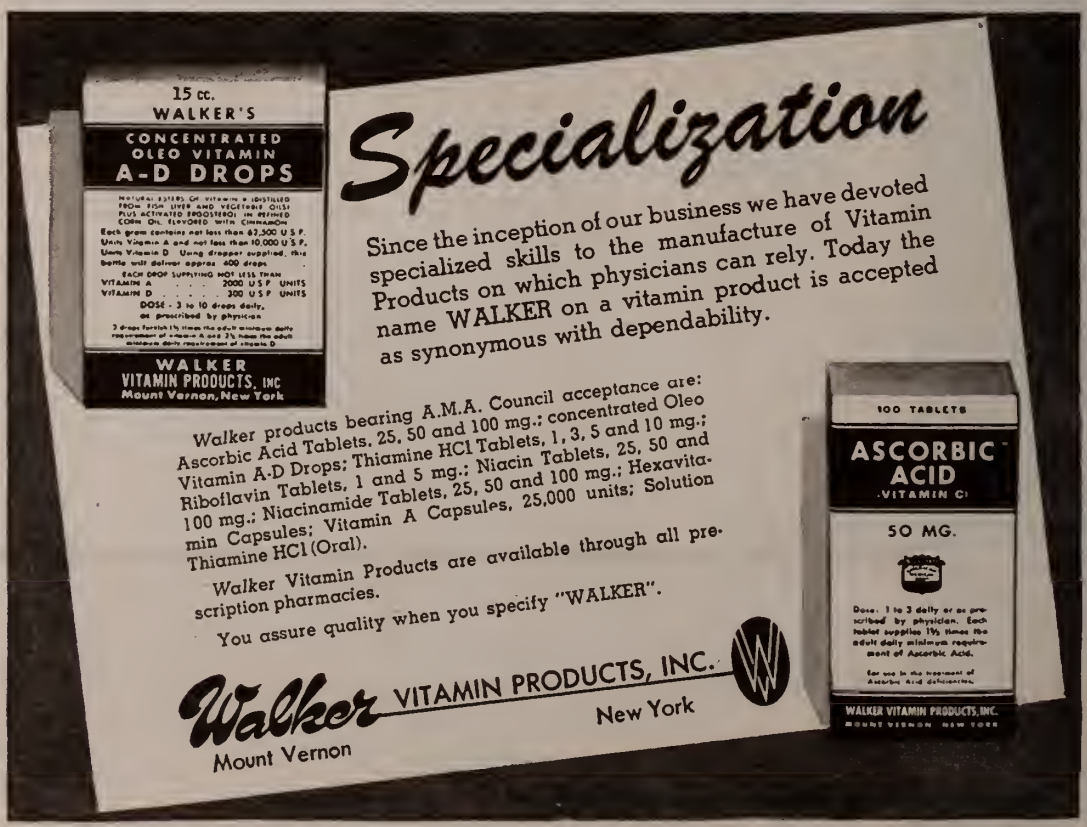
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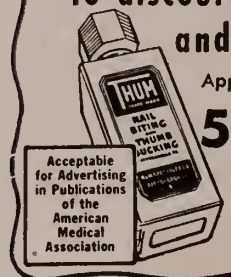
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## CONTAMINATED MILK POSSIBLE SOURCE OF INFANTILE PARALYSIS EPIDEMIC

Investigation of an outbreak of infantile paralysis which occurred at a West Coast naval training school, involving over 100 persons, pointed to food, probably milk contaminated by flies, as the common source of infection.

The investigators, writing in the June 15 issue of *The Journal of the American Medical Association,* are: Lieut. Col. David M. Goldstein, M.C., Army of the United States, W. McD. Hammon, M.D., D.P.H. from the George Williams Hooper Foundation, University of California, San Francisco, and Henry R. Viets, M.D., lecturer on neurology, Harvard Medical School, Boston.

Within an eight day period, beginning the first week of September 1943, 18 cases of polioencephalitis were diagnosed with at least 100 persons showing milder infections. The authors noted that in one-half of the 18 cases paralysis, either moderate or severe, developed. Polioencephalitis is an inflammatory disease of the gray substance of the brain which may paralyze the muscles supplied by the brain, neck and chest nerves.

Eliminating other possible sources of contamination the authors say that although "a few cases of poliomyelitis had been reported in the town during the summer months, the rates were lower than in many other areas in the state.


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"The only common contributing factors in the outbreak appeared to be the residence in the school, the use of soft drinks (principally milk shakes) at the school's fountain and the eating of meals at the mess hall," the article states.

"Flies were found present in great numbers, both in and out of the buildings. Many were present in the barracks, but the number was excessive in the mess hall and the milk barn.

"Milk from the milking machines in the barn passed directly through cooling coils into a funnel with a cloth diaphragm. On this cloth, at the time of our inspection, numerous flies were being rinsed with a stream of milk. Open, steam sterilized milk cans into which the milk from the funnel was run contained many living flies, and drowned flies were in the condensed steam at the bottom."

The authors conclude that "since the possibility of milk borne epidemics of poliomyelitis has been suggested by other investigators, and since the present outbreak contained somewhat similar characteristics of rapid onset (within eight days) and milk contaminated with flies as a probable common source of infection, it was highly suggestive that we were dealing with a milk borne epidemic. Since flies have been found repeatedly contaminated with poliomyelitis virus, this source of contamination seems quite possible."

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## TOO GENERAL USE OF PENICILLIN SALVES CAUSES SKIN REACTIONS

### Three Physicians Say Drug Produces Skin Inflammation With Scaling, Lesions And Watery Discharge

Numerous people indiscriminately using penicillin ointment mixtures report suffering from skin inflammation, according to three Cincinnati physicians, who add that "with increasing use of penicillin, reactions may become even more frequent."

The physicians, writing in the June 13 issue of *The Journal of the American Medical Association,* are Leon Goldman, Forman Friend and Lester M. Mason, all from the Department of Dermatology and Syphilology of the University of Cincinnati College of Medicine.

Although reports by many investigators have been presented on reactions to penicillin, the authors state that "our interest concerns chiefly the contact irritations from topical applications of penicillin in ointment mixtures."

With this in mind, the doctors made a study of approximately 350 patients with various types of skin lesions and found that 16 reacted to contact with penicillin by developing a skin inflammation, 13 of whom are here reported. The article points out that "although penicillin ointment was used all over the body and even in the mouth . . . , facial lesions seemed pre-



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disposed to the development of a dermatitis in spite of the fact that lesions of this area were not the most frequent lesions treated."

Approximately 32 male patients with acute infections of the face caused by micro-organisms were treated with penicillin ointment, and of those patients nine developed a contact dermatitis. Approximately eight female patients with varying types of this same infection on the face and neck were treated with penicillin ointment and three developed a dermatitis. The authors state that their study suggests caution in the use of penicillin ointments in facial infections, especially in the male. One other contact dermatitis due to penicillin ointment was found on the legs of a patient.

The article reveals that reactions to penicillin ointments are manifested in several different forms, such as skin rash, measle-like eruptions with scaling of the skin or the eczematous type with inflammatory skin disease, lesions and a watery discharge.

"In our present state of knowledge regarding the causes of penicillin dermatitis," the authors write, "not too much practical advice can be given regarding prophylaxis except to use penicillin only where and when indicated . . . for superficial topical therapy and not indiscriminately for everything."


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Simply drop one Clinitest Tablet into test tube containing proper amount of diluted urine. Allow time for reaction, compare with color scale.

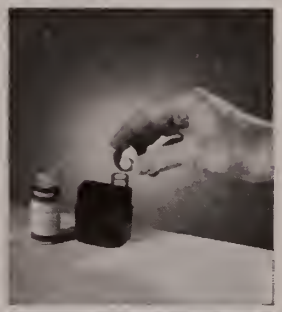
**FOR OFFICE USE**

Clinitest Laboratory Outfit (No. 2108) Includes — Tablets for 180 tests, test tubes, rack, droppers, color scale, instructions. Additional tablets can be purchased as required.

**FOR PATIENT USE**

Clinitest Plastic Pocket-Size Set (No. 2106) Includes — All essentials for testing — in a small, durable, pocket-size case of Tenite plastic.









Order from your dealer.

Complete information upon request.

**AMES COMPANY, Inc. Elkhart, Indiana**

**DERMAL PENATRIN — ZEMMER**

Formula: Resorcin, Zinc Oxide, Carbolic Acid, combined with Menthol, Glycerin and Penatrin (greaseless base). INDICATIONS — ANTI-PRURITIC AND SEDATIVE. Used in the treatment of minor skin irritations, insect bites, ivy poisoning and sunburn. Supplied in ½ oz. and 1 oz. tubes. Literature and prices on request.

**THE ZEMMER COMPANY**

Chemists To The Medical Profession

Oakland Station Pittsburgh 13, Pa.




IL-8-46

MORPHINE AND OTHER DRUG ADDICTIONS

Selected patients who wish to make good and learn how to keep well; methods easy, regular, humane. Dr. Weirick's Sanitarium, Elgin, Ill.

**THE STOKES SANITARIUM** 923 Cherokee Road, Louisville, Kentucky

Our **ALCOHOLIC** treatment destroys the craving, restores the appetite and sleep, and rebuilds the physical and nervous condition of the patient. Liquors withdrawn gradually, no limit on the amount necessary to prevent or relieve delirium.

**MENTAL** patients have every comfort that their home affords.

The **DRUG** treatment is one of gradual Reduction. It relieves the constipation, restores the appetite and sleep; withdrawal pains are absent. No Hyoscine or rapid withdrawal methods used unless patient desires same.

**NERVOUS** patients are accepted by us for observation and diagnosis as well as treatment.

**E. W. STOKES, Medical Director, Established 1904.**

Telephone—Highland 2101

Tuberculosis is always a dangerous disease. In the Navy it has exceptional significance because of the unavoidable close quarters of existence, the importance of continuous physical fitness and the rich resources available for its control by exclusion, prevention, detection and care. Emil Bogen, M.D. and G. H. Strickland, M.D. The Am. Rev. of Tbc., Dec., 1945.

## Classified Ads

**RATES FOR CLASSIFIED ADVERTISEMENTS**—For 30 words or less: 1 insertion, $3.00; 3 insertions, $8.00; 6 insertions, $14.00; 12 insertions, $24.00; from 30 to 50 words: 1 insertion, $4.00; 3 insertions, $10.50; 6 insertions, $20.00; 12 insertions, $30.00. Extra words: 1 insertion, 10c each; 3 insertions, 25c each; 6 insertions, 40c each; 12 insertions, 50c each. A fee of 25c is charged for those advertisers who have answers sent care of the Journal. Cash in advance must accompany copy.

FRIEDMAN PREGNANCY TESTS require only 48 hours. Write for mailing tube and vial. Established 1938. Price $5.00. Pregnancy Diagnostic Laboratories, H. S. Lames, D.V.M., Dysart, Iowa.

3/47

**WANTED:** Young, married Navy doctor, Illinois license, recently returned. Desires assistantship with older physician or group clinic. Requests for personal interviews invited. Will travel. Dr. John Douglas, 5632 N. Spaulding, Chicago.

**ESTABLISHED HOSPITAL FOR LEASE OR SALE**—A Sanitarium for nervous, mental, alcoholic and drug cases doing an excellent business. Established in 1904. It is necessary to see the institution to appreciate its real value. Write Dr. E. W. Stokes, 923 Cherokee Road, Louisville 4, Kentucky for further information.

HABIT-FORMING PROPERTIES OF PAIN RELIEVING DRUG EMPHASIZED

Emphasizing the fact that Demerol, a substitute drug for morphine, has habit-forming properties, H. J. Anslinger, Commissioner of Narcotics, Washington, D. C., writing in the July 13 issue of *The Journal of the American Medical Association*, says:

"Now comes an article by Paul de Kruif in the June issue of the Reader's Digest entitled 'God's Own Medicine—1946' under the headline 'The pain-fighting power of demerol is as miraculous as that of morphine—without the opiate's danger of addiction.' This article adroitly makes no reference to the work of Dr. C. K. Himmelsbach of the United States Public Health Service and Drs. Hans H. Hecht, Paul H. Noth and F. F. Yonkman of Detroit, all of whom warned of the danger of addiction.

"Demerol was placed under federal narcotic control by the Congress because of evidence given before that body of its dangerous properties. Some of the persons referred to in de Kruif's article could have attended the hearings before the Ways and Means Committee and could have testified as to what they thought about the drug, but they elected to remain silent.

"I fear a wave of Demerol addiction if physicians who read this article believe what I consider the reckless and dangerous statements made by de Kruif that the drug is free from addiction properties. This is information somewhat similar to that which appears in the circular distributed by the manufacturer of Demerol to push sales. Had this article been prepared on a strictly scientific basis it would have sounded a strong warning about the danger of addiction. Our files contain numerous cases of addiction involving the use of Demerol."

Demerol, also known as Dolantin, was discovered in Germany and made its appearance several years ago in the Argentine. The author points out that both of these countries immediately placed the drug under strict control.



**UNSCENTED COSMETICS**

**FOR THE ALLERGIC PATIENT**

AR-EX Cosmetics are the only complete line of *unscented cosmetics* regularly stocked by pharmacies. To be certain that your perfume sensitive patients do not get scented cosmetics, prescribe *AR-EX Unscented Cosmetics*. SEND FOR FREE FORMULARY.

AR-EX

**FREE FORMULARY**

DR._____

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STATE_____

AR-EX COSMETICS, INC., 1036 W. VAN BUREN ST., CHICAGO 7, ILL.




In response to requests from pediatricians, we are now also marketing PABENA—precooked oatmeal, enriched with vitamin and mineral supplements. PABENA closely resembles Pablum in nutritional qualities, and offers the same features of thorough cooking, convenience and economy. Supplied in 8-ounce cartons. Samples on request.

MEAD JOHNSON & COMPANY, EVANSVILLE, IND., U.S.A.

Academy of Medicine
2 E 103 St
New York N Y
Exch



COLONIAL HALL
One of the 14 Units in "Cottage Plan"

# FOR NERVOUS DISORDERS

MAINTAINING the highest standards for more than a half century, the Milwaukee Sanitarium stands for all that is best in the care and treatment of nervous disorders. Photographs and particulars sent on request.

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G. H. Schroeder
Business Manager

# MILWAUKEE SANITARIUM

**WAUWATOSA—WISCONSIN**

PHYSICIAN'S CHICAGO OFFICE—1117 Marshall Field Annex—Wednesdays, 1-3 P.M.—Central 1162

# The ILLINOIS Medical Journal

VOL. 90 NO. 3

*September, 1946*

In This Issue

War and Disease

+

Vitallium Plates Used In Repair of Large Hernias

+

Recent Developments in the Treatment of Hypertension

(See Page 37 for complete Table of Contents)

OFFICIAL JOURNAL OF THE ILLINOIS STATE MEDICAL SOCIETY

# NEW SEARLE AMINOPHYLLIN SUPPOSITORIES




For more convenient and effective rectal administration of Aminophyllin,* Searle Research has produced

## AMINOPHYLLIN SUPPOSICONES
### (SEARLE BRAND OF AMINOPHYLLIN SUPPOSITORIES)

Differing from all other types of suppositories, Searle Aminophyllin Supposicones are molded with a new base material which liquefies rapidly in the rectum, permitting complete absorption of the Aminophyllin, but which remains *stable and solid at temperatures up to 130° F. outside the body.*

Searle Aminophyllin Supposicones are non-irritating to the rectal mucosa—require no anesthetic—are of proper size and shape for easy insertion and retention.
Each Aminophyllin Supposicone contains 500 mg. (7½ grs.) Searle Aminophyllin. Packaged in boxes of 12.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

*Searle Aminophyllin contains at least 80% of anhydrous theophyllin

*Supposicones is the registered trademark of G. D. Searle & Co., Chicago 80, Illinois*

**SEARLE**

*RESEARCH IN THE SERVICE OF MEDICINE*

Entered as Second-Class Matter July 21, 1919, at the Post Office, Oak Park, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate of postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Office of Publication, 715 Lake Street, Oak Park, Ill.

# *Personal Service*

—given each policyholder

—by specialists engaged exclusively in this field

—based on 47 years experience in successfully handling more than 60,000 malpractice claims

—enables The Medical Protective Company to provide you Prevention, Defense and Protection against loss

—as you provide service for your patients




THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

prompt local relief for pai



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PHARMACEUTICAL MANUFACTURERS, NEWARK 7, N. J.

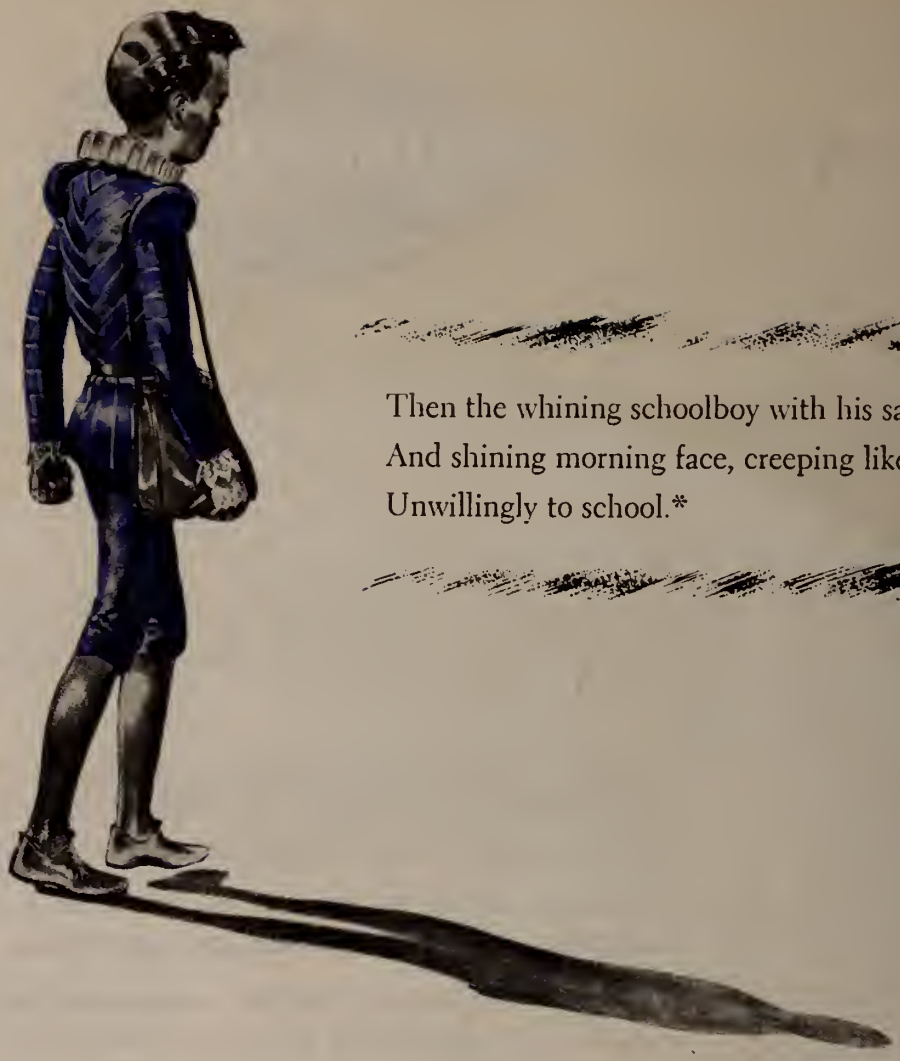
nd spasticity in the throat

After tonsillectomy, and during acute tonsillitis and pharyngitis, the use of Aspergum affords these widely recognized advantages:

1. **Increases salivary flow; continuously laves with acetylsalicylic acid all oropharyngeal areas, including those seldom reached by gargles or irrigations.**
2. **Stimulates activity of muscles of mastication and deglutition; reduces local spasticity and stiffness.**
3. **By enhancing patient comfort, encourages early ingestion of suitable diet, hastens convalescence.**
4. **Assures patient cooperation through ready acceptance by all, including children.**

Ethically promoted, never advertised to the laity. In packages of 16; moisture-proof bottles of 36 and 250 tablets.

# Aspergum



Then the whining schoolboy with his satchel,
And shining morning face, creeping like snail
Unwillingly to school.*

ZYMENOL easily overcomes constipation and irregular bowel habits induced by youthful procrastination. This brewers' yeast in emulsion** aids restoration of physiological bowel content through zymolysis and tends to normalize intestinal motility with its natural vitamin B complex content. Soft, comfortable evacuation is assured without habit-forming catharsis or colloidal bulkage. Because ZymenoL is agreeably palatable, sugar-free, and the only emulsion effective in teaspoon dosage, your youthful patients are seldom control problems. For acceptable bowel management in *this* age group, specify ZymenoL.

OTIS E. GLIDDEN & CO., Inc., Evanston, Illinois.

**Glidden-processed brewers' yeast assures zymolytic factors and natural vitamin B complex without live yeast cells.

**ZymenoL**

**Brewers' Yeast in Emulsion**

**FOR EFFECTIVE BOWEL MANAGEMENT**




*Second of a series depicting the Seven Ages of Man. From Shakespeare's "As You Like It."

*Introducing a new treatment for*



## COMMON EYE INFECTIONS

Sodium sulfacetiuiide is the only sulfonamide which ean be dissolved to a conecntration as high as 30 per cent at physiologie pH. It is, therefore, both surpassingly bacteriostatie against a wide variety of organisms and virtually non-irritating—attributes which make it an especially valuable topical chemotherapeutic agent for prophylaxis and treatment of infections of delieate oeular tissues. SODIUM SULFACETIMIDE SOLUTION 30% has marked and rapid penetrating powers when applied locally in the form of eyedrops, reaching a high conecntration in the cornea and conjunctiva within five minutes.

# SODIUM SULFACETIMIDE SOLUTION 30% (*Sodium* SULAMYD)

is indicated for the local treatment of acute infectious conjunctivitis, acute corneal ulcer, acute blepharoconjunctivitis, hypopyon keratitis and for prophylaxis following foreign body injuries and abrasions of the cornea and conjunctiva.

Dosage: One drop placed in the affected eye every two to four hours. Available on prescription in 15 cc. amber, eyedropper bottles.

Trade-Mark SULAMYD—Reg. U.S. Pat. Off.

SCHERING

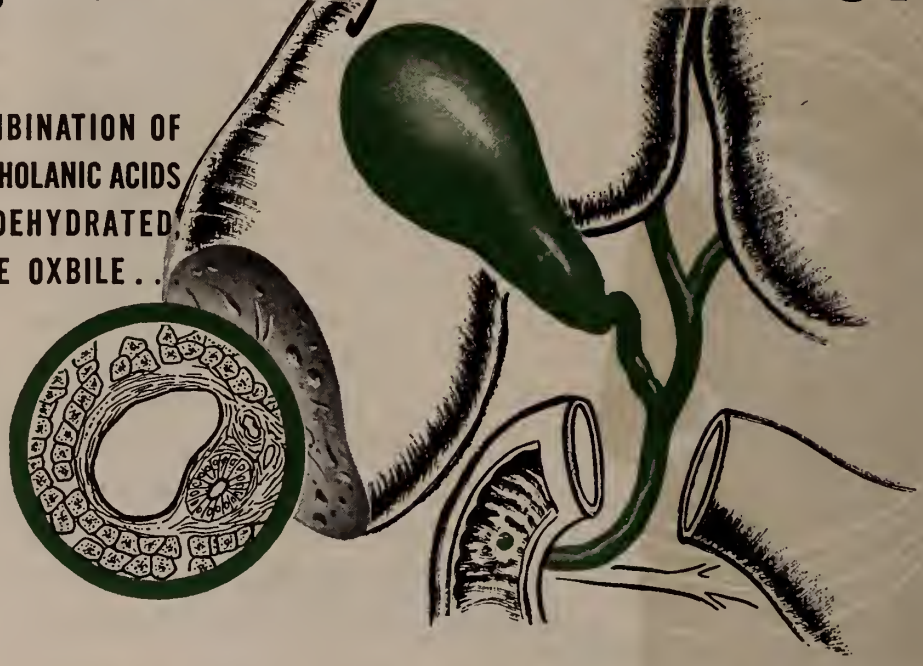
*Schering* CORPORATION · BLOOMFIELD, N. J.

IN CANADA, SCHERING CORPORATION LIMITED, MONTREAL

ANOTHER SIGNIFICANT CONTRIBUTION BY MALTBIE RESEARCH CHEMISTS

*Announcing* **CHOLANOX**

A COMBINATION OF KETOCHOLANIC ACIDS AND DEHYDRATED WHOLE OXBILE . .



THE PHYSIOLOGICAL APPROACH TO THE MANAGEMENT OF

**BILIARY DISEASE . . .**

**HYDROCHOLERESIS** A mixture of ketocholanic acids (approximately 90% dehydrocholic acid) to combat biliary stasis by increased production of free flowing bile.

**BILE SALT REPLACEMENT** Dehydrated bile for the efficient digestion of fats, absorption of vitamins and minerals and to stimulate intestinal motility.

**SUPPLIED:** In orange-coated tablets in bottles of 100, 500 and 1000 each containing 1¾ gr. ketocholanic acids and 1¾ gr. oxbile dehydrated.

*Complete literature on request.*

*Cholanox*

THE MALTBIE CHEMICAL COMPANY
*Founded in 1888*
NEWARK, N. J.

FOR BETTER MEDICAL MANAGEMENT OF BILIARY DISEASE




Nupercainal helps the most

**Nupercainal,** the soothing onesthetic ointment contoining 1% Nupercaine, is noted for its sustoined effect in the relief of pain associated with the above and other ono-rectal conditions.

Many physicians employ Nupercoinol, too, in poinful proctologicol ond voginol examinotions.

Availoble in tubes of 1 ounce with applicotor and in jors of 1 pound.

**Nupercainal**

Nupercainal and Nupercaine...*Trade Marks Reg. U. S. Pat. Off.*

**CIBA PHARMACEUTICAL PRODUCTS, INC.**
**SUMMIT, NEW JERSEY**
In Conada: **Ciba Company Limited, Montreal**

Gelu-cillin 'WARNER'

50,000 UNITS OF PENICILLIN PER TABLET

Pleasing taste results in greater patient acceptance

GELU-CILLIN tablets are singularly free of the usual moldy odor and taste of most oral penicillins

More comfort during maintenance of penicillin blood levels

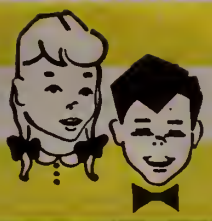
High potency provides greater convenience in day and night therapy




*Supplied in packages of 12 hermetically sealed scored tablets*

WILLIAM R. WARNER & COMPANY, INC. • NEW YORK • ST. LOUIS

# IN A RECENT STUDY OF 512 * CHILDREN





Those receiving no medication showed an increase in the incidence of dental caries of 65 per cent. **65%**



Those receiving tablets of calcium fluoride alone showed an increase of 32 per cent. **32%**

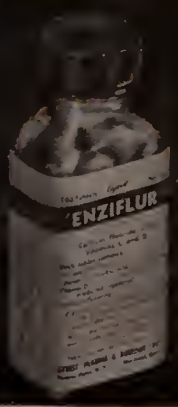


Those receiving a combination of calcium fluoride with vitamins C and D ("ENZIFLUR" Tablets) showed an increase of only 15 per cent. **15%**

## "ENZIFLUR"

*Reg. U. S. Pat. Off.*

TABLETS
(Lozenges)




Each lozenge provides:

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|---|---|
| Calcium fluoride | 2.0 mg. |
| Vitamin C (ascorbic acid) | 30.0 mg. |
| Vitamin D (irradiated ergosterol) | 400 I.U. U.S.P. XII |

**IMPORTANT:** "ENZIFLUR" Lozenges should be allowed to dissolve slowly in the mouth, thus bringing the surfaces of the teeth in contact with the fluorine-bearing saliva.

**AYERST, McKENNA & HARRISON Limited**
22 East 40th Street, New York 16, N. Y.

Ayerst

*Strean, L. P., Beaudet, J. P.: New York State J. Med. *45*:2183 (Oct. 15) 1945.




▪ ▪ ▪ during Convalescence . . . in Dysmenorrhea . . . following Childbirth . . . at the onset of the Menopause . . . following Bereavement or Misfortune . . . in Old Age . . .

. . . *Dexedrine* may be relied upon to increase the patient's accessibility to treatment; to effect a remarkable improvement in mood and outlook; and to aid in restoring a normal grip on life and living.

**Dexedrine Sulfate tablets**
(dextro-amphetamine sulfate)

Smith, Kline & French Laboratories, *Philadelphia*

new! improved treatment

*for* *coryza*
*sinusitis*
*rhinitis*
*nasal congestion*

# 'PROTHRICIN'

*antibiotic nasal decongestant*

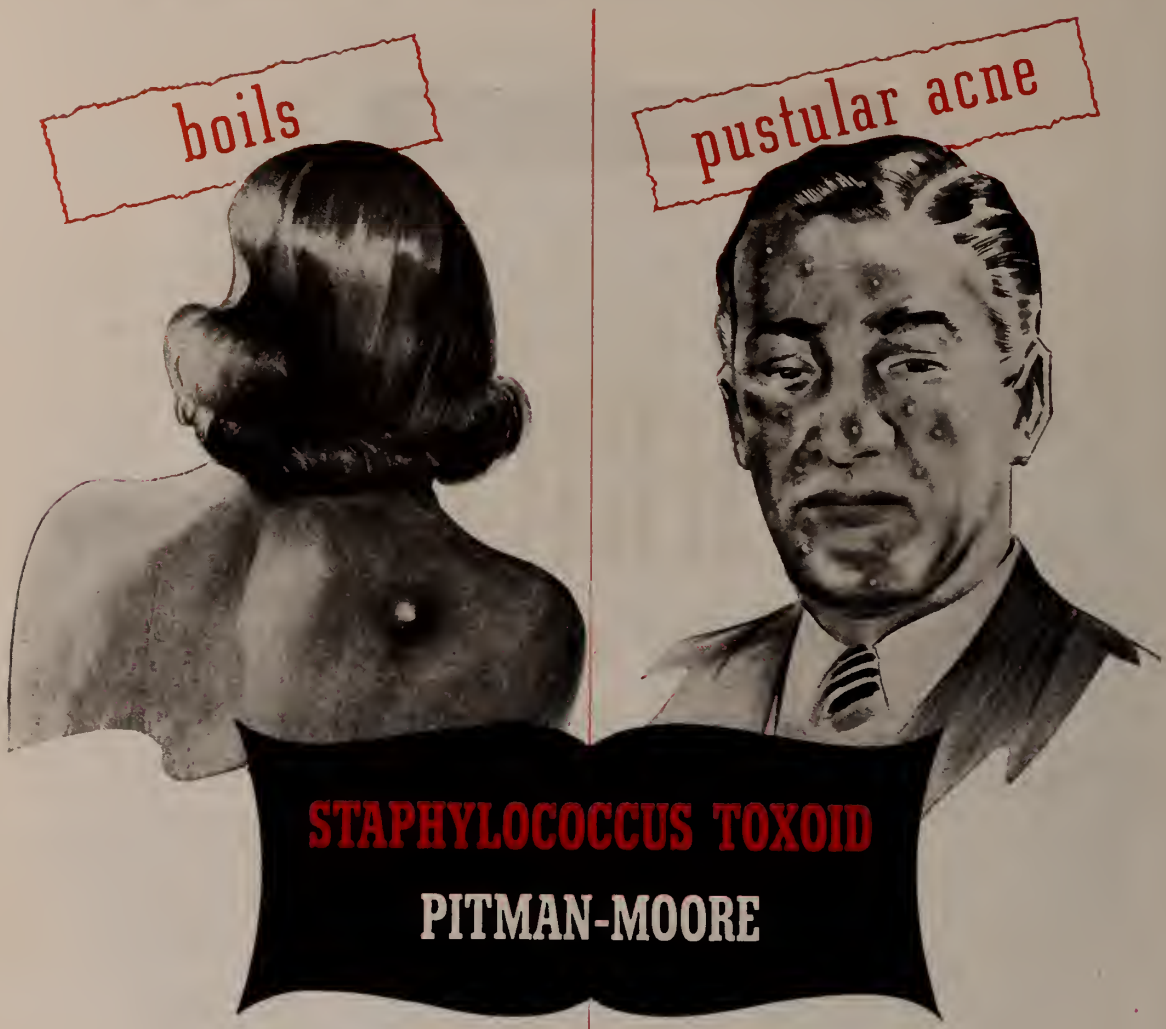
***because:***

| | |
|---|---|
| 1 | 'PROTHRICIN' decongestant contains *tyrothricin* (0.02%), potent, nontoxic topical antibiotic with wider antibacterial scope than the sulfonamides; quicker, more prolonged local antibiotic action than penicillin; low surface tension; greater permeability and stability than penicillin. |
| 2 | 'PROTHRICIN' decongestant maintains its antibacterial efficiency even in the presence of pus and mucus. |
| 3 | 'PROTHRICIN' decongestant serves to re-establish normal intranasal function since it is isotonic, with a buffered pH of 5.5-6.5, does not impair normal intranasal physiologic processes, and does not interfere with ciliary activity. |
| 4 | 'PROTHRICIN' decongestant is clear and free-flowing, unlike intranasal sulfonamide suspensions, and does not form mucosal crusts that may block drainage. |
| 5 | 'PROTHRICIN' Antibiotic Nasal Decongestant also contains 'Propadrine' hydrochloride (1.5%), a highly efficient vasoconstrictor, notably free from undesirable side-effects of ephedrine and its analogs. |

SHARP & DOHME

*Supplied in 1-ounce bottles with dropper assembly*

***SHARP & DOHME, PHILADELPHIA 1, PA.***




AMONG the many conditions which especially enlist the sympathy of the physician—and tax his efforts to ameliorate the psychic as well as the somatic symptomatology—are boils and acne.

A growing literature reports the value of Staphylococcus Toxoid in the prophylaxis and therapy of various staphylococcic pyodermas and localized pyogenic processes due to *S. aureus* and *albus*. The toxoid induces the production of staphylococcus antitoxin in immunized persons, and there is accumulating evidence of its value in producing active immunity to the dermonecrotic and hemolytic elements of the toxins of *S. aureus* and *albus*, irrespective of the strain of the infecting organism.

Staphylococcus Toxoid (Pitman-Moore) is supplied in 5 cc. vials containing in each cubic centimeter the toxoid derived from 1,000 necrotizing doses of the toxin. Preserved with 1:10,000 sodium ethyl mercuri thiosalicylate. Comprehensive information with each package.

**RECOMMENDED FOR TREATMENT AND PREVENTION OF**

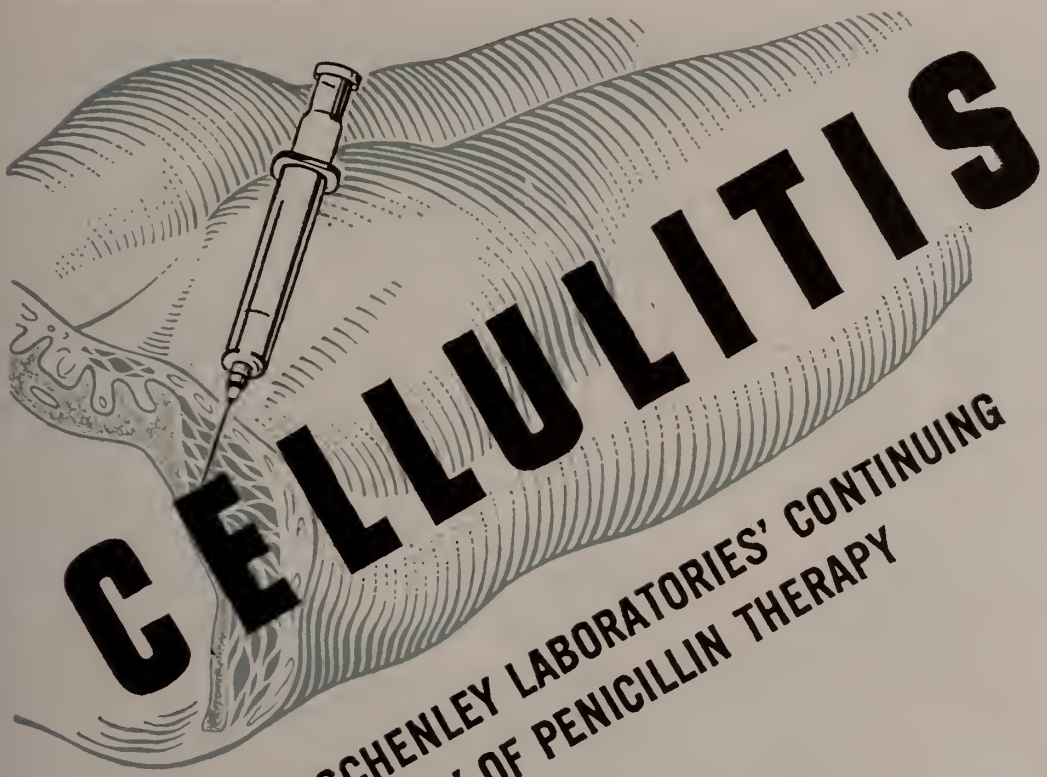
- Recurrent styes, boils, carbuncles
- Pustular acne associated with furunculosis
- Recurrent migratory staphylococcus abscesses of soft tissues and bone
- Staphylococcal infection of accessory nasal sinuses
- Other staphylococcal infections

ACCEPTED AMERICAN MEDICAL ASSN.

PITMAN-MOORE COMPANY

PHARMACEUTICAL AND BIOLOGICAL CHEMISTS

Division of Allied Laboratories, Inc. · Indianapolis 6, Indiana



# CELLULITIS

## No. 3 IN SCHENLEY LABORATORIES' CONTINUING SUMMARY OF PENICILLIN THERAPY

Cellulitis caused by penicillin-sensitive organisms readily responds to penicillin therapy. By the early administration of penicillin in adequate doses, suppuration may be prevented and prompt resolution of the inflammatory process obtained. When abscess formation has occurred, penicillin will localize and control the infection but surgical evacuation of the purulent material may be required to effect a cure.

The administration of penicillin combined, when indicated, with surgical, supportive, and other measures, will in most instances rapidly control and eradicate the infection. Thus, the duration of the disease is shortened, and the possibility of complications reduced to a minimum.

A daily total of 160,000 to 480,000 units, depending upon the severity of the infection, in divided doses every 2 to 3 hours by the intramuscular route will usually be adequate to effect a cure. Duration of the course will depend upon response to therapy. If thought desirable, as a supplement to parenteral administration, penicillin may be employed by local injection or instillation of solutions containing 5,000 to 50,000 units per cc.

**WOLLGAST, C. F.:** *The Clinical Use of Penicillin: A Report of 115 Cases Treated in an Army Hospital, Texas State J. M. 40:225 (Aug.) 1944.* **FARQUHARSON R. F.; GREEY, P., & TOWNSEND, S. R.:** *Results of Penicillin Therapy: A Report for the Joint Services Penicillin Committee, Canad. M. A. J. 53:1 (July) 1945.*

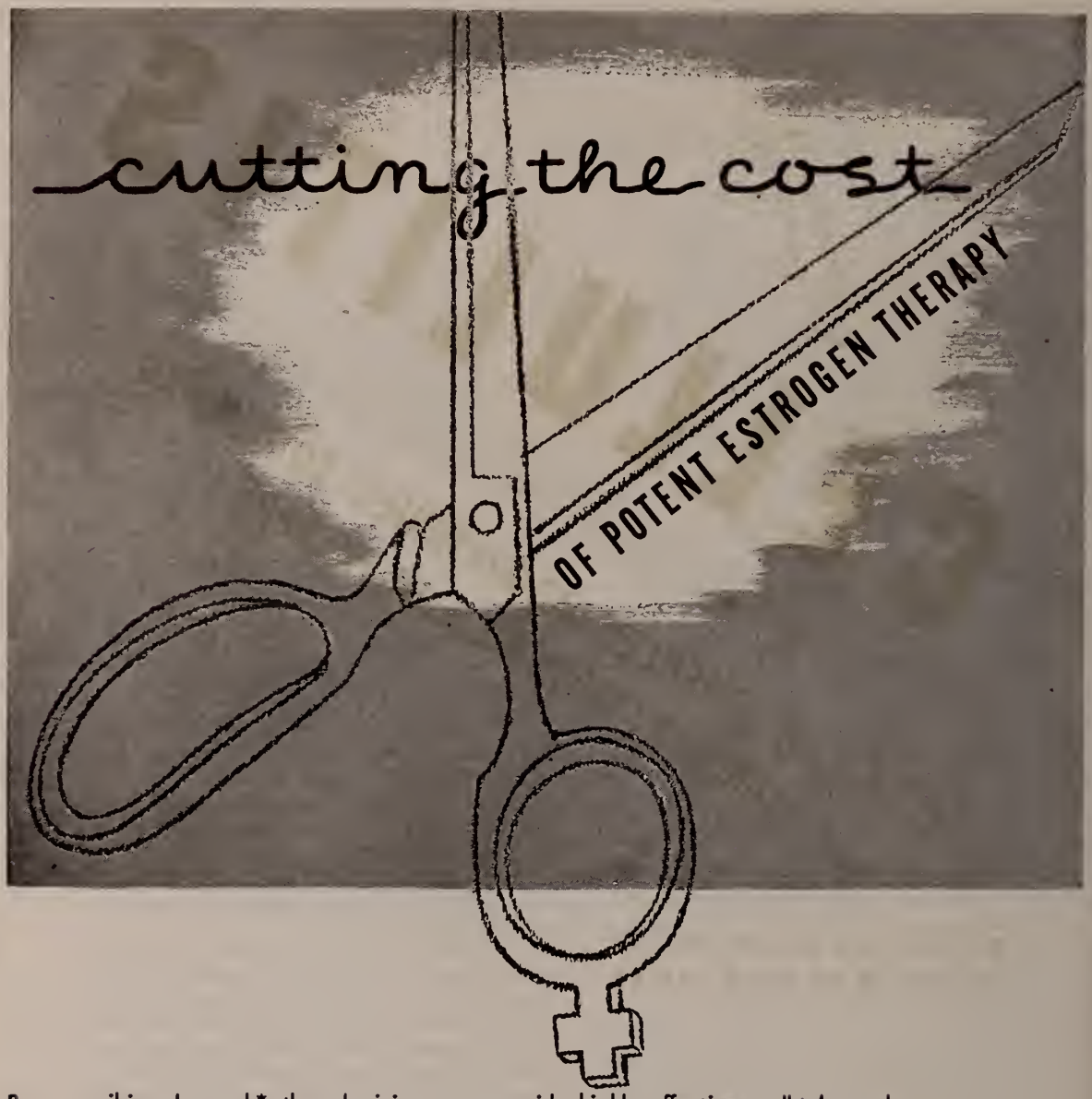
### BEFORE YOU DECIDE ON THE PENICILLIN OF YOUR CHOICE

For many years, Schenley has been among the world's largest users of research on mycology and fermentation processes. In addition, Schenley Laboratories manufactures a complete line of superior penicillin products —products thoroughly tested for potency and quality. These two important facts mean you may give your patients the full benefits of complete penicillin therapy.

### SCHENLEY PENICILLIN PRODUCTS

Penicillin Ophthalmic Ointment Schenley
Penicillin Ointment Schenley
Penicillin Troches Schenley
Penicillin Tablets Schenley
Penicillin Schenley

**SCHENLEY LABORATORIES, INC.** Executive Offices: 350 Fifth Avenue, N. Y. C.




By prescribing Lynoral,* the physician can provide highly effective, well-tolerated, economical estrogen therapy for his patients—even for those of restricted means. Lynoral is the Roche-Organon brand of ethinyl estradiol which is "highly effective by the oral route . . . and from five to twenty times as potent as diethylstilbestrol by mouth."[1] Because of its exceptionally high potency, Lynoral has a dependable estrogen effect in surprisingly small amounts. In fact, doses measured in hundredths of a milligram usually suffice to provide gratifying relief of menopausal symptoms at a cost within the means of nearly every patient. Lynoral tablets, each containing 0.05 mg of ethinyl estradiol, are available in bottles of 30, 60, 250, and 1000; each tablet is scored to facilitate dosage adjustment.

**ROCHE-ORGANON, INC., ROCHE PARK, NUTLEY 10, N. J.**

* Reg. U. S. Pat. Off.

[1] J. Hoffman, Female Endocrinology, W. B. Saunders Co., Philadelphia, Pa., 1944, p. 709

**LYNORAL**

*'ROCHE-ORGANON'*



*To restore nasal patency in colds and sinusitis . . .*

Neo-Synephrine decongests promptly . . . clears the nasal airways for greater breathing comfort . . . promotes sinus drainage. Relief lasts for several hours. Virtual freedom from compensatory vasodilatation precludes development of dependency symptoms.

# Neo-Synephrine

BRAND OF PHENYLEPHRINE HYDROCHLORIDE

*For Nasal Decongestion*

**THERAPEUTIC APPRAISAL:** Prompt, prolonged nasal decongestion without appreciable compensatory recongestion; virtual freedom from local and systemic side effects; sustained effectiveness on repeated use.

**INDICATED** for symptomatic relief of the nasal congestion of common colds, sinusitis and allergic rhinitis.




**ADMINISTRATION** may be by dropper, spray or tampon, using the ¼% in most cases, the 1% when a stronger solution is indicated.

**SUPPLIED** as ¼% and 1% in isotonic saline and ¼% in Ringer's with aromatics, bottles of 1 fl. oz.; ½% jelly in convenient applicator tubes, ⅝ oz.

Stearns

DETROIT 31, MICHIGAN

NEW YORK KANSAS CITY SAN FRANCISCO WINDSOR, ONTARIO SYDNEY, AUSTRALIA AUCKLAND, NEW ZEALAND

Trade-Mark *Neo-Synephrine* Reg. U. S. Pat. Off.




*For doctors' convenience-*

**VITAMIN D CONTENT OF FORMULAC INCREASED FROM 500 TO 800 U.S.P. UNITS**

IN LINE with customary usage of vitamin D among pediatricians — and in response to requests from leading practitioners—the vitamin D content of FORMULAC Infant Food has been increased from 500 to 800 U.S.P. units.

FORMULAC originally had a vitamin D content of 500 units, more than adequate for the needs of *average* infants. At the request of pediatricians for added protection to cover even *exceptional* cases (such as prematures and others requiring larger amounts of vitamins in their diet) the vitamin D content has been raised 300 U.S.P. units.

For further information about FORMULAC, and for professional samples of this new vitamin-and-mineral fortified Infant Food, mail a card to National Dairy Products Company, Inc., 230 Park Avenue, New York 17, N. Y.

*Distributed by* **KRAFT FOODS COMPANY**

**NATIONAL DAIRY PRODUCTS COMPANY, INC.**

**New York, N. Y.**

ACCEPTED AMERICAN MEDICAL ASSN.

NATIONAL DAIRY Sealtest PRODUCTS CORP.

# "...Unto the Third and Fourth Generation..."



PROTECTION against congenital syphilis can often be accomplished by treatment of the expectant mother.

Proper antisyphilitic therapy during pregnancy can prevent or control syphilis in the infant . . . lower the mortality rate in fetal syphilis . . . reduce the frequency of premature labor—even if the antisyphilitic course is comparatively short and the child not cured. Syphilis in mothers can be well started toward symptomatic and serologic cure.

MAPHARSEN (meta-amino-para-hydroxyphenyl arsine oxide (arsenoxide) hydrochloride) gives maximum therapeutic effect—rapid disappearance of spirochetes and prompt healing of lesions. Minimal untoward reactions are less severe than those observed after use of arsphenamines.

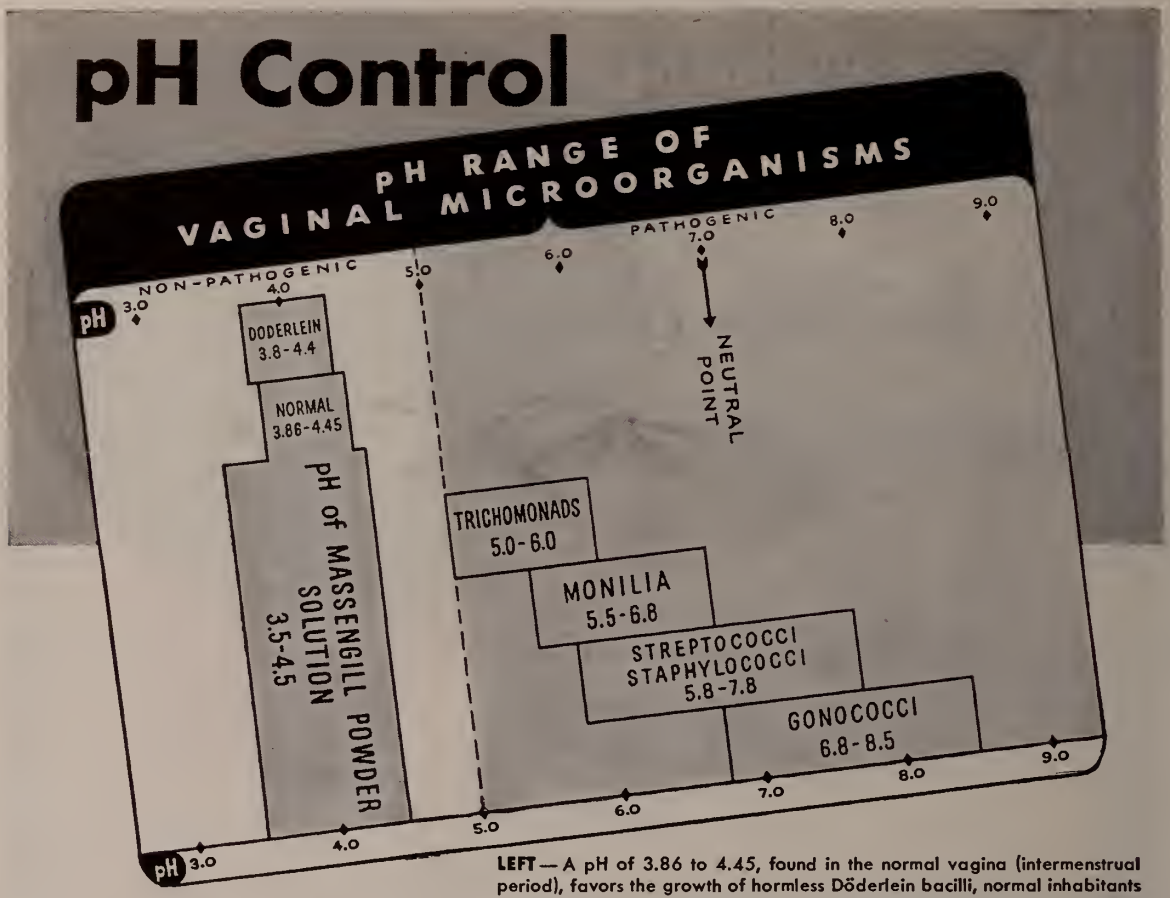



# MAPHARSEN

PARKE, DAVIS & COMPANY

DETROIT 32, MICHIGAN

# pH Control




**LEFT**—A pH of 3.86 to 4.45, found in the normal vagina (intermenstrual period), favors the growth of hormless Döderlein bacilli, normal inhabitants of the voginal tract. Massengill Powder solution presents a pH of 3.5 to 4.5.

**RIGHT**—The pH range, 5.0 to 9.0, most favorable to the development of pathogenic organisms.

SINCE the average woman wants and needs advice regarding a proper douche, her physician is confronted by the problem of choosing an effective preparation which is safe, noncaustic and nonirritating. Massengill Powder may be recommended with assurance because it combines therapeutic efficacy, preventive action and hygienic value, with virtual freedom from irritant properties. Its particular advantage lies in control of vaginal pH.

The normal vagina is protected against the influence of pathogenic organisms by a pH incompatible with their growth. Hence restoration of a normal pH presents the simplest, most direct form of vaginal therapy. Massengill Powder, by providing the desired pH, represents a powerful antibacterial weapon.

Due to its effect upon vaginal pH and to its cleansing action, Massengill Powder solution is equally suitable for regular use in personal hygiene and in the therapy of a wide range of vaginal affections.




# MASSENGILL
## POWDER

Massengill Powder is supplied in glass jars in 3-oz., 6-oz., 16-oz., and 5-lb. sizes.

**THE S. E. MASSENGILL COMPANY**
**Bristol, Tenn.-Va.**

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# ANGINA PECTORIS

## *and other Manifestations of*

# CORONARY INSUFFICIENCY

The following episodes may be prevented by appropriately regulated administration of a vasodilator having a *sustained* effect:

**FOR THE PERSON**

- *who is compelled to stop and rest when climbing a flight of stairs.*
- *who suffers "indigestion" and "gas" on exertion, or after a heavy meal.*
- *who is stricken with precordial pain on unusual exertion or emotion, or when exposed to cold.*

The vasodilatation produced by Erythrol Tetranitrate Merck begins 15 to 20 minutes after administration, and lasts from 3 to 4 hours.

*It is generally agreed that the acute attack of anginal pain is most readily relieved by the prompt removal of the provocative factor, and by the use of nitrites. For prophylactic purposes—to control anticipated paroxysms—the* delayed but prolonged action *of erythrol tetranitrate is effective. Erythrol tetranitrate, because of its slower* and more prolonged *action, is also considered preferable for the purpose of preventing nocturnal attacks.*

# ERYTHROL TETRANITRATE MERCK

(ERYTHRITYL TETRANITRATE)

*Council* Accepted *Accepted*

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*Manufacturing Chemists*

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# INTO THE PICTURE

". . . in chronic cases of long standing due to prolonged and varied causes, more than iron is required for permanent recovery." — *R. Gottlieb: Canad. M. A. J. 47: 456 (Nov.) 1942.* HEMATOCRIN* offers a hematinic combination that is widely recognized as fitting into the picture of satisfactory hematopoiesis...the three-way approach to a sustained response.

**IRON** — as dried ferrous sulfate, protected against oxidation by a special process of saccharation.

**LIVER** — liver residue, containing the "anti-secondary anemia" fraction of Whipple.

**B-COMPLEX** — to aid in promoting a normal cellular metabolism, stimulate appetite, and help maintain gastrointestinal function.

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Reg. U. S. Pat. Off.

*Hematinic Capsules*

Each capsule supplies:

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|---|---|
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| Sucrose | (1 gr.) 65 mg. |
| Liver Residue† | (1½ gr.) 0.1 Gm. |
| Niacinamide | 5.0 mg. |
| Thiamine HCl ($B_1$) | 0.5 mg. |
| Riboflavin ($B_2$) | 0.34 mg. |
| Pyridoxine HCl ($B_6$) | 0.08 mg. |
| Calcium Pantothenate | 0.08 mg. |

† Containing the "anti-secondary anemia" fraction of Whipple.

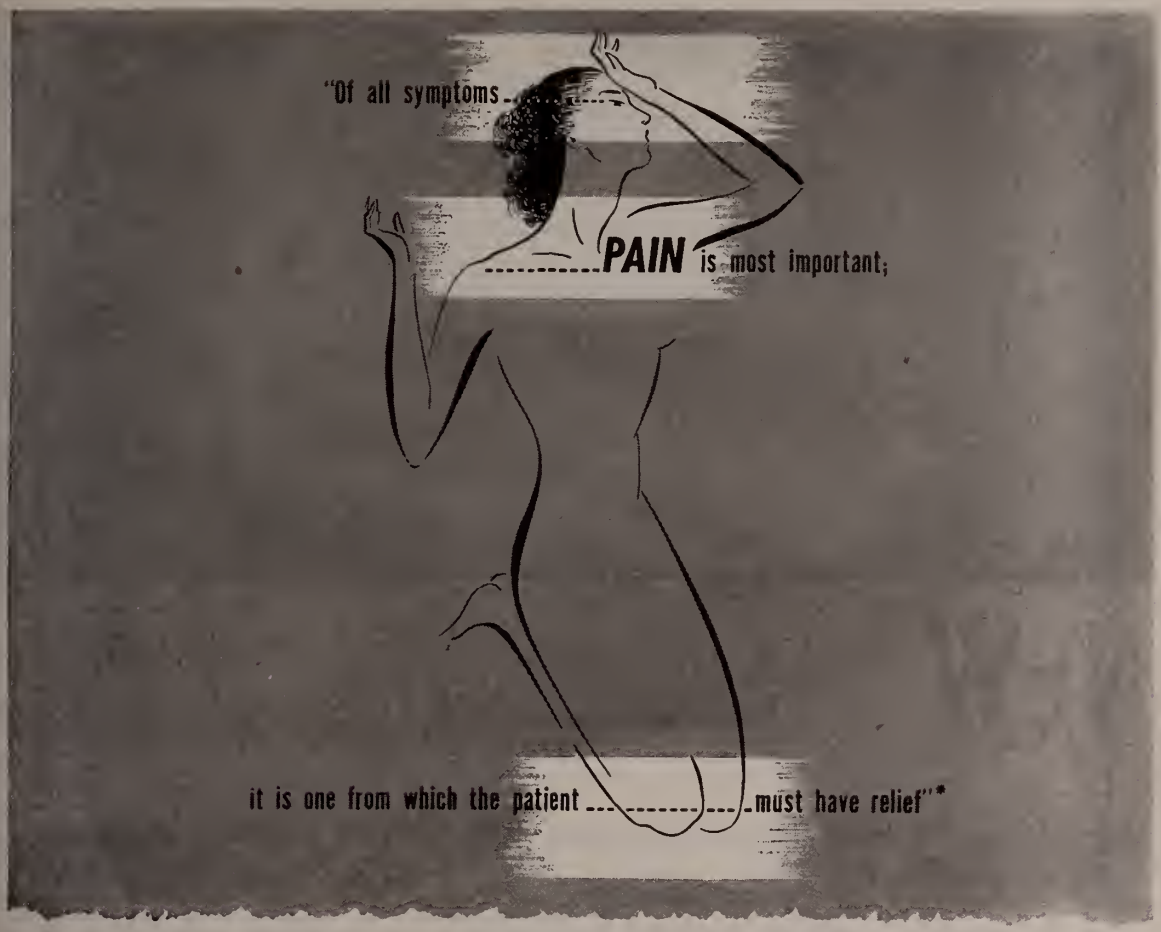
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***The* HARROWER LABORATORY, *Inc.***
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Wherever a general analgesic-sedative is indicated,

# Aspirocal

'McNEIL'

offers three important drugs for their synergistic pharmacologic effect—the potentiation of analgesia.

## Formula

**Each tablet contains:**

**Acetylsalicylic Acid.....4 gr.**
**Calcium Gluconate.....2 gr.**
**Butisol (5-ethyl-5-secondary butyl barbituric acid "McNeil").⅓ gr.**

*Supplied in bottles of 100, 500 and 1000 tablets.*

*Handbook of Therapy, Chicago, American Medical Association, 1935, p. 58.

Aspirocal—although designed for general analgesic and sedative use—requires your prescription. Thus the patient is kept under your absolute supervision and the causation of pain can be checked.

Aspirocal is widely used in headache, the large field of neuralgias and similar conditions, rheumatic and arthritic conditions, and in dysmenorrhea and minor surgical procedures. Caution: Use only as directed.

*A trial supply will be sent to physicians upon request.*

McNeil Laboratories, Inc.
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**Like a vanishing cream in cake form, but with lathering and detergent qualities**

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Dermolate may be used at all ages for cleansing all skins, normal or pathologic. Especially valuable in *soap-irritable skins, contact dermatitis, infantile eczema, occupational dermatoses, surgical scrub-up, soap-aggravative lesions.*

1. I. H. Blank, *Arch. of Derm. and Syph.*, 39: 811-824 (1939) May: "Action of Soap on Skin."

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*Also a representative list of glandular products and pharmaceuticals.*

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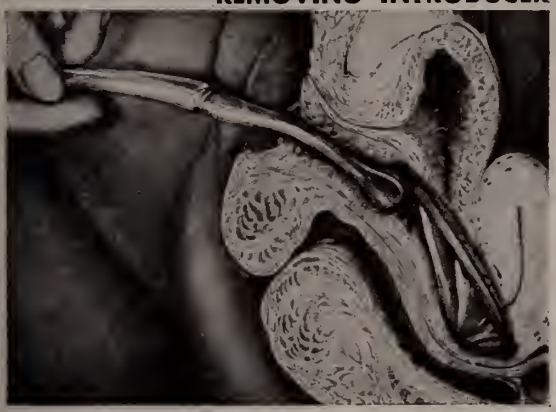


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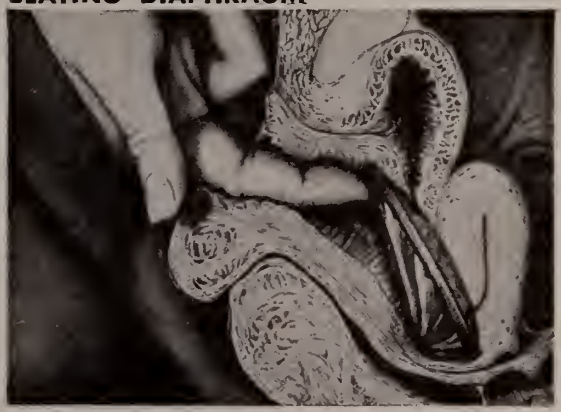


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• Similarly, for sturdy bodies in later years a strong nutritional foundation must be established early in infancy.
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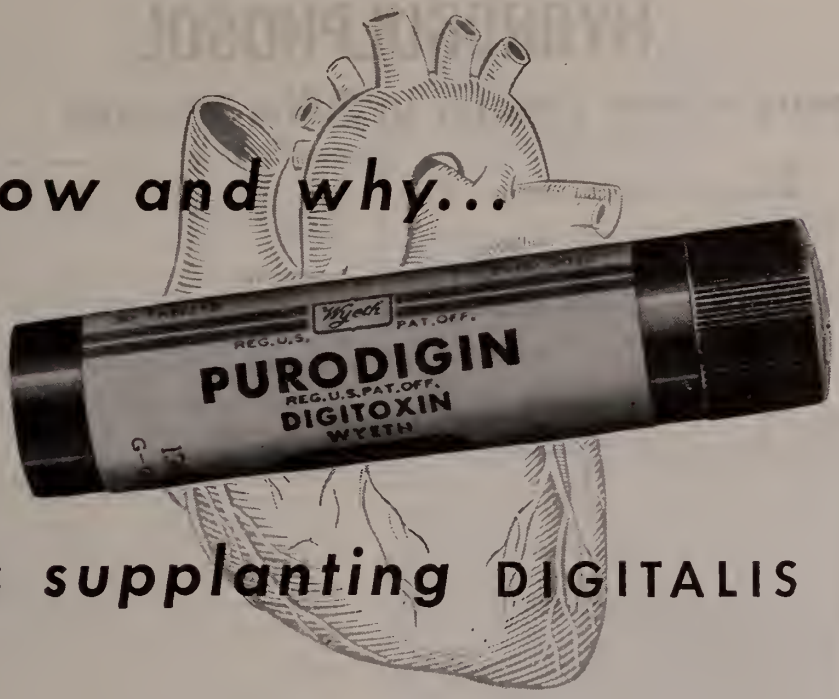
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*Quickly prepared ... easily calculated: 1 fl. oz. Biolac to 1½ fl. oz. water per lb. of body weight.*




## *is supplanting* DIGITALIS

**The average maintenance dose of Purodigin is 0.1-0.2 mg.**



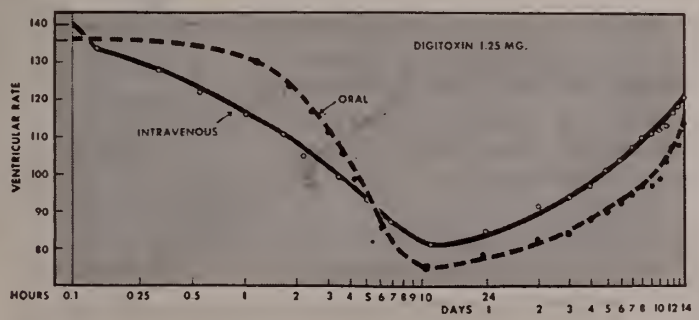
**The average maintenance dose of digitalis is 0.1-0.2 Gm. (1.5-3 gr., or 1-2 U. S. P. units).**



The patient on digitalis can be changed to Purodigin merely by substituting 0.1-0.2 mg. Purodigin for 0.1-0.2 Gm. digitalis.

Purodigin is identical with digitalis in therapeutic effect, rate of cumulation and rate of excretion.

Purodigin has the advantage of constant potency and complete absorption—it differs from digitalis in that it contains no unabsorbable or nontherapeutic components to irritate the gastrointestinal tract.




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REG. U. S. PAT. OFF.

## DIGITOXIN WYETH

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*New!* ***For intravenous injection: 1 cc. ampuls — Boxes of 6***

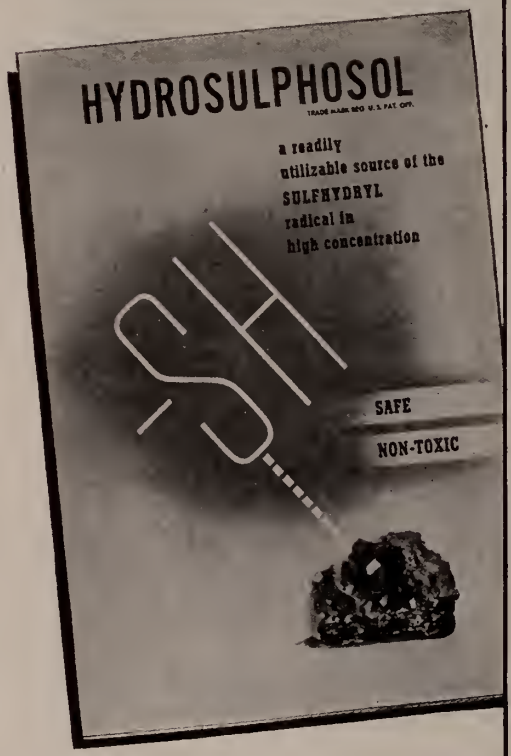
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# HYDROSULPHOSOL

## opens a new chapter in Sulfur Therapy

Dramatic results confirm its value in burns, arthritis, and many conditions in which sulfur imbalance is a clinical factor.




Recommended uses as a home or adjunctive hospital treatment in arthritis—

**FOOT BATH:** Add one ounce of Hydrosulphosol Solution to a large galvanized bucket or container ample in size to immerse both feet and ankles. The water should be about 100 deg. F. at first or a temperature that can be comfortably tolerated. The temperature of such a bath can be gradually raised to 105 deg. F. if this heat can be tolerated. This type bath can be employed also for the arms. Length of bath 20 to 40 minutes.

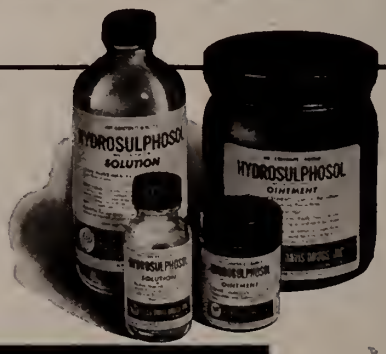
**TUB BATH:** Add two ounces of Hydrosulphosol Solution to a full tub of water at 100 to 102 deg. F. for five to twenty minutes with a patient moving all of his affected joints while submerged in the bath. An authority on this type of therapy points out the hot bath is useful in subacute or chronic generalized rheumatoid arthritis, although some arthritic patients, particularly those who are emaciated and weakened, do not tolerate exposure to heat and are easily exhausted from prolonged hot baths. In such cases the foot bath would be better indicated.

Fluids should be given freely after the bath (or during the bath if marked sweating occurs). If there is excessive perspiration, 2 to 6 tablets of sodium chloride (1 Gm. each) may be given. All patients should rest in bed for at least an hour after the bath.

**ORAL:** 10 to 15 drops of Hydrosulphosol Solution to a glass of water at least three time a day. If initial dosage appears to cause discomfort due to sulfur odor or taste fewer drops can be added to each glass of water until larger amounts can be tolerated easily and without distaste.

**OINTMENT:** Rub Hydrosulphosol Ointment over stiff joints, dry skin or affected areas once or twice daily.

No evidence of toxicity has been reported during the 10 years of experimental study.




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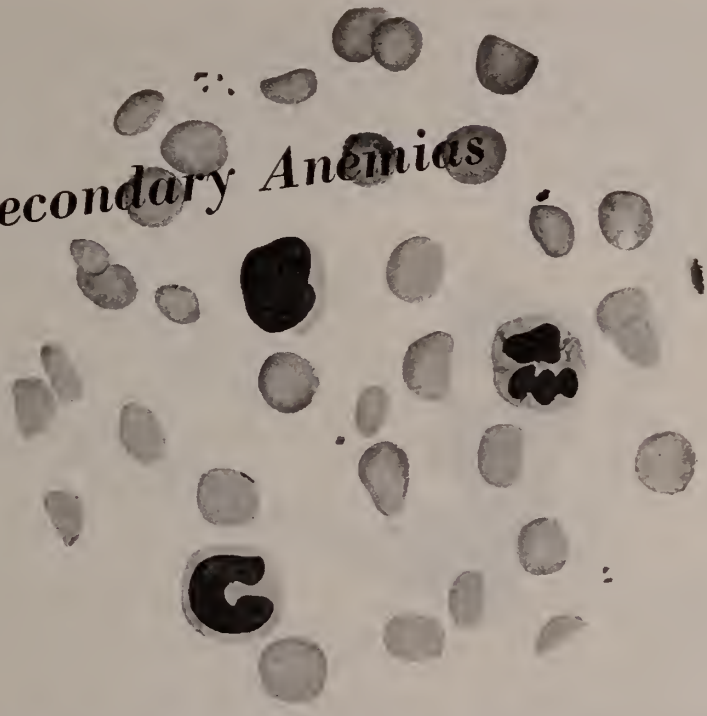
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EACH CAPSULE CONTAINS

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| Riboflavin (vitamin $B_2$) | 2 mg. |
| Nicotinamide | 10 mg. |
| Ferrous sulfate (anhydrous) | 100 mg. |
| Liver concentrate (1 to 20) | 200 mg. |

Prophylactic dose for adults: 1 capsule daily. Therapeutic dose for adults: 2 or 3 capsules three or more times daily, depending on severity of the anemia.

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Brand of
Vitamin B COMPLEX Factors
with LIVER Concentrate and IRON

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HOFFMANN-LA ROCHE, INC., Roche Park, Nutley 10, New Jersey.

*A. T Hertig & R G Livingstone, *New England J. Med., 230*:798, 1944



## to combat

## mental depression in the menopause

". . . because the involutional period is fraught with sadness the different forms of mental disorder of this age may be highly colored with mental depression."*

Severe menopausal depression, marked by apathy and psychomotor retardation, is frequently progressive. Hence, if not promptly and effectively treated, it may seriously impair the patient's normal capacity for useful living.

In such cases, Benzedrine Sulfate helps to overcome the depression, to restore optimism and to reawaken the savor and zest of life. Needless to say, Benzedrine Sulfate is not indicated in the casual case of low spirits, as distinguished from true prolonged mental depression.

*Hinsie, Leland E.: The Person in the Body, an Introduction to Psychosomatic Medicine, New York, W.W. Norton & Co., 1945, p. 223.

Tablets and Elixir

**benzedrine sulfate**

*(racemic amphetamine sulfate, S.K.F.)*

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# introducing harmony in B's and C with Cebefortis



—and a strikingly effective harmony to meet the well-founded popular demand for vitamin C and B factors to repair the drain of disease and operation upon body stores. Here is the score:

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| Pyridoxine Hydrochloride . . | 1.5 mg. |
| Calcium Pantothenote . . . . | 25.0 mg. |
| Nicotinic Acid Amide . . . . | 50.0 mg. |
| Ascorbic Acid . . . . . | 150.0 mg. |

*Bottles of 100 and 500 tablets*

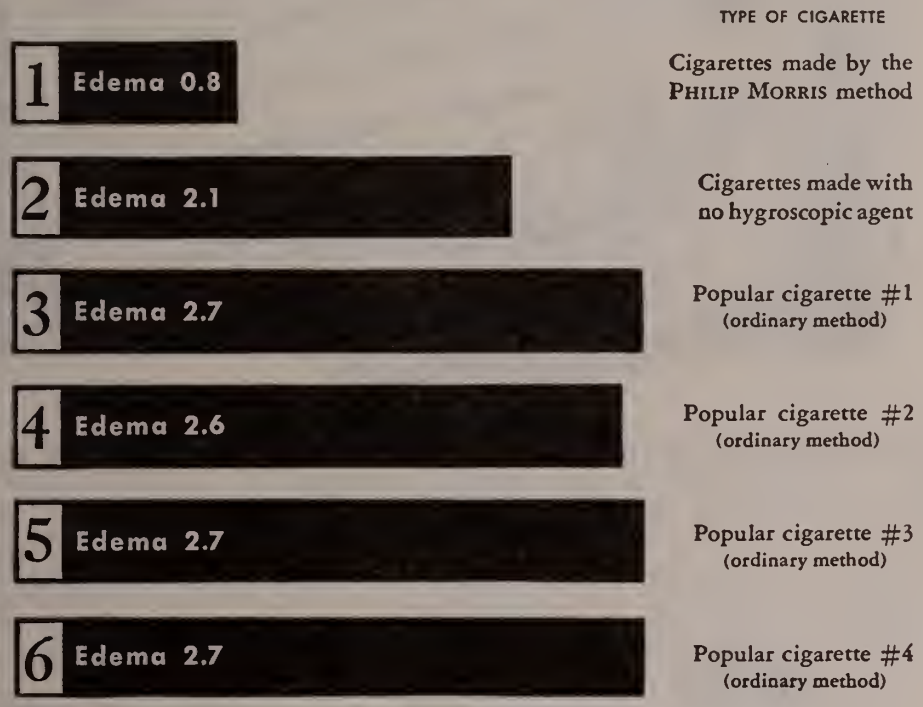
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Upjohn

FINE PHARMACEUTICALS SINCE 1886

# *How* irritation varies from *different* cigarettes

*Tests* made on rabbits' eyes reveal the influence of hygroscopic agents*



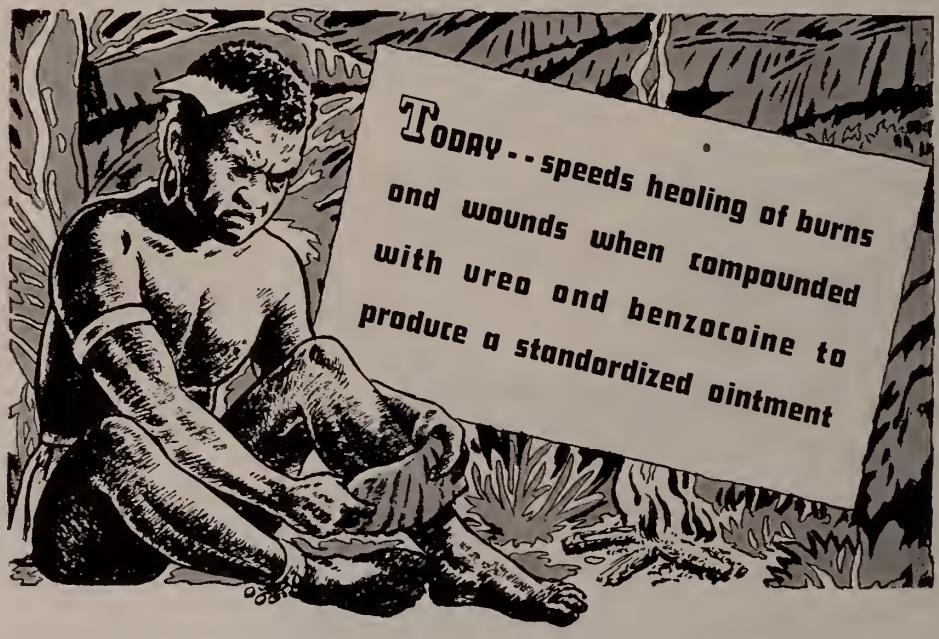

CONCLUSION:* Results show that regardless of blend of tobacco, flavoring materials, or method of manufacture, the irritation produced by all ordinary cigarettes is substantially the same, and measurably greater than that caused by PHILIP MORRIS.

CLINICAL CONFIRMATION:** When *smokers* changed to PHILIP MORRIS, substantially every case of irritation of the nose and throat due to smoking cleared completely or definitely improved.

**N. Y. State Journ. Med. 35 No. 11,590* ***Laryngoscope 1935, XLV, No. 2, 149-154*

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

**CHLOROPHYLL--nature's healing agent**




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*Chlorophyll-Benzocaine-Urea*

1% CHLOROPHYLL speeds regeneration of epidermal tissue.
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***The modern approach to patient instruction***

Latest approved techniques of prenatal care. Illustrated, cartoon-style, to promote reader interest. Text written by University of Michigan Hospital's Obstetrics and Gynecology Department. Sale strictly limited to the medical profession. Write for sample booklet and prices.

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*Active ingredients:*

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*Prescribed For Over A Decade*

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Without any stimulation of the central nervous system whatever, Solutions 'Tuamine Sulfate' (2-Aminoheptane Sulfate, Lilly), when applied intranasally, produce long-lasting, uniform shrinkage of the nasal mucous membrane. Furthermore, Solutions 'Tuamine Sulfate' do not impair ciliary motility and there is no secondary vasodilatation. Solution 'Tuamine Sulfate,' 1 percent, is intended for routine use and is the solution of choice for prescriptions. The 2 percent solution is supplied for application in the doctor's office when a more intense effect may be desired. Solutions 'Tuamine Sulfate' are available at all prescription pharmacies.

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NOTHING could be more appropriate as a gift from a physician to his son than a stethoscope, traditional symbol of medical art. And nothing could be more complimentary to a father than to have his son choose the profession which he himself has followed. There is something basically significant and deeply gratifying about the succession of one member of a family to the position occupied by another. Particularly is this true in medicine.

Eli Lilly and Company enjoys the distinction of having remained under the active direction of one family since its inception seventy years ago. Each succeeding generation has brought to the organization new perspective, new vigor, new strength. Through the years there has been no change in the basic principles on which the business was founded. Honesty, integrity, and unqualified sincerity govern every operation. Specify "Lilly" with full confidence.

*A picture of The Good Samaritan provided the inspiration that*



*eventually led to the founding of Eli Lilly and Company*

The Illinois Medical Journal

September, 1946

VOL. 90, NO. 3

Official Journal of the Illinois State Medical Society

EDITOR — Harold M. Camp. EDITORIAL BOARD — James H. Hutton, Chairman, Frederick H. Falls, Josiah J. Moore, Edwin M. Miller, Chauncey C. Maher, Harry S. Gradle, Harry Culver, Walter Stevenson, Raymond W. McNealy.

# Editorials

## SPECIAL MEETING OF THE HOUSE OF DELEGATES

Springfield, July 28, 1946

A special meeting of the House of Delegates of the Illinois State Medical Society was called by the President and Chairman of the Council to be held at Springfield on Sunday, July 28, 1946. The purpose of the meeting was to consider and act upon a motion and amendments which were approved by the House of Delegates at the closing session during the 1946 annual meeting on May 16th.

These items for consideration pertained to the family group surgical and medical expense policy which had been approved at a special meeting last January and which was being sold throughout the state. Objections had been made to five clauses in the policy. Certain amendments were suggested and approved by the House, and the committee studying prepayment plans for medical and surgical care had been instructed to endeavor to adjust these five points, and then report to the Council, and later, if necessary, to a special meeting of the House of Delegates.

The company writing this policy (the only one which has received committee approval to date) was willing to make some of the suggested changes. Two of them were standard provisions which could not be changed under the insurance code of the State of Illinois, two changes were acceptable to the company, and the fifth and last the company was unwilling to alter at this time.

There were more than 120 official delegates present at this special meeting and the entire forenoon was devoted to a general discussion of the subject contained in the call and listening to the report of the Committee to the House. In the afternoon the committee's report was approved. The former committee which had been functioning for two years resigned, and Chairman of the Council was instructed to form a new committee as soon as possible to carry on this important work.

Following the meeting the Chairman of the Council selected a new committee, the personnel of which was approved by the Council, and notified by the Secretary's office of their appointment. This new committee is composed of:

Dr. Percy E. Hopkins, Chairman, Chicago
Dr. Warren W. Furey, Chicago
Dr. Harold Miller, Chicago
Dr. Charles P. Blair, Monmouth
Dr. Edwin S. Hamilton, Kankakee
Dr. David B. Freeman, Moline
Dr. E. G. Quattlebaum, Jr., Rockford

This new committee will meet as often as is necessary to carry on the work of securing additional insurance companies to write policies meeting the requirements which have been set up by the commitee, the Council, and the House of Delegates. At the present time several reliable carriers have given us assurance of their desire to participate in developing a policy similar to the one already approved. It is our hope that many

reliable insurance companies will enter the field, and through their agency forces, sell this protection to as many citizens of Illinois as possible.

The minutes of this special meeting of the House of Delegates will be published in an early issue of the Illinois Medical Journal so that the entire membership may know what actions were taken. In the meantime it is hoped that physicians in Illinois will become familiar with the protection afforded by this type of coverage to give aid in paying the costs of the so-called catastrophic illness and accidents suffered by the people, especially those in the lower income groups.

At the end of this special meeting the House of Delegates gave a vote of thanks to the old committee and its chairman for the fine work conducted over a period of two years. It was obvious to all that the committee had done a fine job and had paved the way for a smoother functioning of the new committee which has been formed to carry on this important work.

## MEDICOS RATE THE CHEERS FOR SHEER VALUE TO MANKIND

Under the above heading, a most interesting syndicated article appeared in Billy Rose's column in the Chicago Sun, under date of August 7, 1946. When so many people are condemning the members of the medical profession for their alleged shortcomings, and with the ever-increasing threats that the government will take over the practice of medicine, there is indeed a sense of comfort derived through reading this interesting article.

In his article, Billy Rose said:

"For my dough, the most important people in the world are doctors. If you have a bum ticker, if a sick tooth is beating drums inside your head, if your kid breaks out in spots, whom do you holler for? Truman? Henry Kaiser? Adm. Nimitz? In a pig's ear! You send for the man with the little black satchel.

"I wouldn't care if they took 99 per cent of the inventors, politicians and generals and chopped them up for firewood. You can't tell me that this is a better


## ILLINOIS STATE MEDICAL SOCIETY

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| Charles P. Blair | 4th | District, Monmouth | 1949 |
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| Charles H. Hulick | 7th | District, Shelbyville | 1949 |
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| G. C. Otrich | 10th | District, Belleville | 1948 |
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| Everett P. Coleman | At | Large, Canton | 1949 |

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world because it's got an airplane. I don't give a hoot whether I can get to Los Angles in seven hours, seven days or seven weeks.

"To me that silver bird with the cute stewardess is the same gadget that dropped a cup of plutonium on a city and bloop! — no city. If I were putting up a statue to an inventor, my hero would be the obscure Dutchman who invented the microscope.

"Compared with physicians, politicos don't rate very high with me. After being in charge for 5,000 years, they've still got us up the well-known creek. I suppose they mean well, but they always wind up making the same speech, 'as of yesterday, my country is at war with your country.'

"I stood in the streets and hollered with the rest of the peasants when Eisenhower rode up Fifth avenue last summer. I think Ike is a great guy, but let's face it — does he rate as many cheers as Fleming, the man who found penicillin? Not in my book.

"My respect for doctors is not something I came by an hour ago because I needed a midweek piece. I have been tipping my hat to these gentlemen ever since I had a hat. There wasn't much on the obituary page when an old friend of mine, Dr. Emanuel Libman, died a few months ago.

"He was a slender little party with pink cheeks and a library of classical records he never had time to listen to. During his years as head of the great Mount Sinai hospital he charted a good part of what the top specialists know about your heart.

"A lot of people are going to see thousands of extra sunrises because of Manny Libman. Do you know anyone in Congress who has given the world one-tenth as much?

"I know a powerful good medicine man named Jules Lempert, who has devised a startling method of building a window of living tissue into the structure of a dead ear. For years they called him quack, and insisted the operation was impossible.

"Today he lectures at Harvard Medical, and they write articles about him in Readers Digest. At the end of a working day, this talented surgeon can say, 'I have given a man back his hearing.' Do you think Benjamin Fairless of U. S. Steel is nearly so important a citizen?

"In a quiet way, doctor chaps are brothers to the priceless madmen who clean out machine gun nests or claw their way up the slopes of Mount Suribachi. When I was a kid I had scarlet fever, and they tacked up a red sign on my house and nobody could come near me. But a little old geezer with a black bag walked right in.

"I can still see the tiny red veins around his nose, and catch the smell of iodform and tobacco from his rumpled suit. I remember asking my mother, 'Don't doctors get sick?'

"Mom assured me they didn't — but she was fibbing. The list of doctors who were struck down by the bugs they were chasing would stretch from here toValhalla.

"Of course, the great stand-outs of medical science don't need me to beat their drum. The Warner Bros. took care of that some years ago in their 'doctor' cycle. You couldn't go into a theater without seing Paul Muni inoculating rabbits.

"But the doctor in your neighborhood, with the stethescope and 1937 Chevvy, could use a little applause. In a society that rates a guy by how big a check he can write, he knocks his brains out for practically no dough.

"Remember that when you run into real trouble — something bites you in the belly, a sledge-hammer starts knocking at the base of your skull, your heart is pumping like an old hot water bag — it's old Doc Sawbones who comes around and stops the hurt.

To me, that's as important as anybody can get."

At the end of a long day after caring for the sick and afflicted, hearing the stories which must be told in detail by the anxious patient, then perhaps a few emergency calls, the average physician who finds an article complimenting him written by a popular writer who insists that this is not something that came up on the spur of the moment, but that he has been tipping his hat to doctors ever since he had a hat, it will make the tired medico think that after all some do appreciate his services, and that he still has friends outside of his own realm.

It is indeed a pleasure to reproduce this interesting compliment to the members of the medical profession. When we see more of such articles in the future, we shall indeed, be most happy to tell the writer how much we appreciate his commendations.

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## LOYOLA SCHOOL OF MEDICINE HAS NEW DEAN

Dr James J. Smith, former director of physiology for the Eighth Air Force Medical Establishment, has been named Dean of the Loyola University School of Medicine. Dr. Smith began his duties at Loyola on August 1.

A Lt. Colonel in the Medical Corps, Dr. Smith was recently released by the Army after five years of service in the United States and England. He succeeds Dr. Francis J. Braceland who has been on leave of absence with the Navy.

While in the Army, Dr. Smith spent most of his time in the field of physiology. As head of that department with the Eighth Air Force, he worked on field research in aviation physiology, dealing with problems of anoxia and oxygen equipment, cold, high altitude, frostbite, and fatigue.

Dr. Smith served as Chief of the Medical Safety Division of the Office of Flying Safety with the Army in Winston-Salem, N.C., after his

return to this country from the Eighth Air Force Headquarters in England.

In that capacity he was concerned with medical problems in flying safety, medical aspects of injury and fatalities in flying accidents, carbon monoxide poisoning, and problems in pilot error.

A graduate of St. Louis University, medical school, Dr. Smith took graduate work at Northwestern University, where he received an M.S. degree in Pathology and a Ph.D. degree in Physiology.

Dr. Smith served for a year as an assistant in Pathology at Cook County hospital. He was an assistant instructor in the department of Clinical Pathology at the University of Illinois medical school, and also did research and teaching at Northwestern medical school before entering the Army in 1941.

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## THE ADMINISTRATIVE DETAILS OF THE ILLINOIS STATE MEDICAL SOCIETY PROGRAM FOR CARE OF VETERANS WITH SERVICE-CONNECTED DISABILITIES AT HOME BY PHYSICIAN OF CHOICE

As every member of the Illinois State Medical Society knows, the agreement between the Society and the Veterans Administration has been signed and every physician desiring to do so, may participate in this program to provide veterans with care at home for service-connected disabilities.

Each member of the Society has been sent a 5 x 8 record card and has been asked to fill it out and return it to the office of the secretary. These cards will be turned over to the Veterans Administration, and the physicians expressing willingness to work under this agreement, will be appointed as "designated physicians" of the Veterans' Administration.

In offering the veteran an opportunity to use his family doctor or a specalist in his home town with the government paying the bills, the program gives recognition to the age-old physician-patient relationship, and presents to the medical profession an opportunity to prove that private practice can handle this job.

Full cooperation of all our membership in giving medical care to veterans will aid in the decentralization plans of the Veterans Administration and will minimize the expansion of government hospital facilities and institutionalized medical care.

*Administrative Details of the Plan.* — The mechanics of this program are really simple. When a member of the Illinois State Society has returned his 5 x 8 record card to the office of the secretary, it is noted in his office, and the card forwarded to the Regional Office, Veterans Administration, 366 W. Adams Street, Chicago. The Veterans Administration will issue an appointment to each physician, and will send him a supply of forms to be used.

ONLY VETERANS WITH SERVICE-CONNECTED DISABILITIES ARE ELIGIBLE TO RECEIVE MEDICAL CARE AT THE EXPENSE OF THE VETERANS ADMINISTRATION.

Exception: Ex-Service women are eligible for out-patient treatment for service-connected disabilities only; *however, hospital care for this class of beneficiaries may be authorized in private hospitals, under contract, for either service or non-service connected conditions.*

ONLY PHYSICIANS WHOSE NAMES ARE ON THE LIST OF FEE-DESIGNATED PHYSICIANS OF THE VETERANS ADMINISTRATION WILL BE ELIGIBLE FOR REIMBURSEMENT BY THE VETERANS ADMINISTRATION FOR SERVICES RENDERED AN ELIGIBLE VETERAN, EXCEPT IN EMERGENCIES (See paragraph "Emergency Treatment".)

*Applying For Authorization.* — When a veteran applies direct to a designated physician for treatment, the physician must submit the request for authority to treat the veteran to the regional office. APPROVAL IS MANDATORY. (Form 2690) AILMENT MUST BE SERVICE CONNECTED.

1. Routine approval for non-emergent illness should be secured before any work is done. A supply of Form 2690 will be sent each designated physician.

2. Out-patient emergencies should be treated and Form 2690 filed within FIVE DAYS.

3. Hospital emergencies should be treated and Form 2690 filed within 72 hours. (A phone call to The Medical Director (Dearborn 7500),Chicago Regional Office - Veterans Administration. 366 West Adams Street, Chicago 6, Illinois, will secure information relative to service-connection

of the ailment, and will give the physician information as to what procedure to follow.)

The Veterans' Administration office upon receiving the request for treatment will advise the physicians as to whether or not treatment is authorized and will submit any other information that may be deemed helpful to the physician.

At present all requests for authorization should be addressed to the Regional Office in Chicago except when the applicant resides in the cities of Rockford, Springfield and East St. Louis. In these cities the requests may be addressed to the sub-regional offices direct, and the addresses are as follows:

Rockford: 301-305 South Main Street
Springfield: 410 East Monroe Street
East St. Louis: 435 Missouri Avenue.

As soon as possible other sub-regional offices will be opened, and eventually the entire state of Illinois will be serviced through regional area offices as the members of the Veterans Administration are able to decentralize and distribute case histories and records.

*Submission of Physician's Statement.* — A physician who has rendered service in an authorized case should submit his statement for services rendered to the Regional Office where the treatment was authorized. Payment will be made direct to the physician by the Veterans' Administration.

*What is Emergency Treatment?* — When a veteran requires emergency treatment he should be treated immediately by the physician selected or called.

If the physician wishes to ascertain whether or not the Veterans' Administration will assume responsibility, a telephone call should be made by the physician to the Veterans' Administration office in the area nearest the physician's office. (Chicago except for Rockford, East St. Louis and Springfield). The physician will be advised as to what procedure to follow.

*What Out-Patient Service Includes.* — This program for out-patient care of ELIGIBLE veterans includes: Examinations and Treatments in the physician's office, in the veteran's home, and in a private hospital which has contracted with the Veterans Administration to provide hospital service for veterans with service-connected disabilities.

At the discretion of the Veterans Administration, veterans with certain types of disabilities may be requested to report to a veterans Administration hospital for treatment.

*Prescriptions to be written.* — The following information is issued to physicians relative to prescription services for eligible veterans and to relieve Veterans Administration pharmacy activities of the heavy burden imposed by the volume of prescriptions of designated physicians.

The Veterans Administration and the Illinois Pharmaceutical Association have entered into an agreement similar to that now enjoyed by the Illinois State Medical Society and the Veterans Administration. Their procedure is as follows:

1. Physicians may write prescriptions for eligible veterans on their regular prescription blanks. Whenever possible physicians should include the veteran's "C number" on the face of such prescriptions.

2. All prescriptions must be dated the day written and this date must be within the period of authorization to treat the specified beneficiary.

3. The physician must sign his name on the back of such prescription, over the statement: "I am authorized to treat and prescribe for the above-named Veterans Administration patient." This statement (but not the signature) may be printed, rubber stamped, typed, or written.

4. This signed statement of authorization, which may be made ONLY BY A DESIGNATED PHYSICIAN, for a veteran authorized to be treated for a SERVICE-CONNECTED disability, constitutes authorization to any participating pharmacy to fill such prescriptions within ten (10) days of the date written, and receive reimbursement from the Veterans Administration.

5. All prescriptions or copies of prescriptions for eligible Veterans Administration beneficiaries will be sent by the participating pharmacies to their state association monthly. The Association will forward all such prescriptions to the Regional Office for payment.

*We present a Hypothetical Case.* — For your information and to illustrate the use of V.A.F. forms, we will present here a hypothetical case to be of whatever assistance possible, in explaining how the necessary "paper" work will be carried out.

Veterans Administration
Medical Form 2690
Rev. July 1938

## REQUEST FOR AUTHORITY FOR TREATMENT

Chicago, Illinois (Place) July 23, 1946 (Date)

To Chief Medical Officer,
Veterans Administration
366 West Adams Street
Chicago 6, Illinois
(Location of office)

JONES, John D. (Name of beneficiary) 3-397 399 79 (C-number)

1346 S. River Road, Chicago
(Address of beneficiary)

### I—REQUEST TO BEGIN TREATMENT

1. The above named applied to me 7-23-46 (Date) requesting out-patient treatment.
2. *This applicant has never before been treated by me. He exhibited Certificate of Discharge (certificate of discharge; other papers) indicating that he was enlisted 5-3-42 (date) and was discharged honorably (honorably; not dishonorably; for disability) on 7-11-45 (date) and that his organization was 101st Airborne Infantry (specify) and rank T/Sgt. (specify)
*This applicant last received authorized treatment from me on or about _____ (date)
3. His complaints were Chills and fever
My clinical findings were — Temperature — 103

My present diagnosis is Malaria
4. His condition *(was) (was not) medically emergent. He is *(able) (not able) to report at my office. Hospitalization *(is) (is not) indicated at present.
5. *I rendered no treatment. *I rendered emergency treatment, as follows:
Quinine Sulfate
6. *I recommend _____ (number) treatments. *I request authorization to cover my emergency treatment, and 2 (number) additional treatments.

Joseph Doe, M. D., M. D.
(Signature of Physician)

*Delete inapplicable words.

Form 7522 (AUTHORIZATION FOR FURNISHING MEDICAL OR DENTAL SERVICE) will be sent to you by the Regional Office as follows:

VETERANS ADMINISTRATION
**AUTHORIZATION FOR FURNISHING MEDICAL OR DENTAL SERVICE**

DATE: July 25, 1946

FROM: ORIGINATING OFFICE
Regional Office - Veterans Administration
366 West Adams Street,
Chicago 6, Illinois

TO:
Dr. Joseph Doe
1000 Blank Street
Chicago, Illinois

SEE INSTRUCTIONS ON REVERSE SIDE

SERVICE TO BE FURNISHED TO

NAME: JONES, John D. C-NUMBER: 3 397 399 79

ADDRESS: 1400 River Road SERVICE OR DENTAL NO.:

CITY: Chicago STATE: Illinois DATE OF CLAIM: TYPE WAR: II

TYPE DISCH. NO. SERVICE: Hon. Inf. DATE OF ENL.: 5/3/42 DATE DISCH'D.: 7/11/45

DATE OF BIRTH: PLACE OF BIRTH:

YOU ARE AUTHORIZED TO FURNISH THE FOLLOWING SERVICE TO THE ABOVE-NAMED VETERAN

- ☐ PHYSICAL EXAMINATION
- ☐ ORAL EXAMINATION
- ☐ OTHER
- ☐ OUT-PATIENT DENTAL TREATMENT
- ☒ OUT-PATIENT MEDICAL TREATMENT
- ☐ HOSPITALIZATION
- ☐ DOMICILIARY CARE
- ☐ OBSERVATION

- ☐ THE ABOVE-NAMED VETERAN WILL REPORT FOR SERVICE ON OR ABOUT _____ 19___
- ☐ YOU ARE REQUESTED TO NOTIFY THE ABOVE-NAMED VETERAN WHEN TO REPORT
- ☐ ABOVE-NAMED VETERAN HAS BEEN INSTRUCTED TO CONTACT YOU FOR APPOINTMENT

NATURE OF SERVICE AUTHORIZED: HISTORY AND DIAGNOSIS

Medical treatment for: MALARIA. In accordance with your request of July 23, 1946.

ONE (1) Emergency Office Treatment. (Formal authorization of emergency office treatment rendered July 23, 1946, received this office July 24, 1946)

TWO (2) Additional Office Treatments for: MALARIA

Authorized to a Designated Physician for the reason there is no Salaried Physician available.

PLEASE SUBMIT YOUR BILL IN DUPLICATE

FEE-BASIS TREATMENT MUST BE LIMITED TO THE ABOVE-AUTHORIZED SERVICE. PRIOR AUTHORITY MUST BE REQUESTED FOR ANY ADDITIONAL SERVICE

| CLASS OF BENEFICIARY | CLASS OF DENTAL EXAMINATION OR TREATMENT |
|---|---|
| V.A. Svc.Ltrs of 9/19/45 & 11/20/45 | |
| NO. OF TREATMENTS AUTHORIZED | PERIOD COVERED BY THE AUTHORIZATION |
| SEE ABOVE CONFIRMATION | 7/23/46 to 7/31/46 |
| FEE AUTHORIZED | THE FOLLOWING PAPERS ARE ENCLOSED |
| $2.00 per Office Treatment | Forms 2577, 2690, & 2690a |
| FOR OFFICE USE | SIGNATURE AND TITLE OF AUTHORIZING OFFICER |
| 3670100.001<br>7 SE R 3208 0155-6000 | SAMPLE: C. H. Ogden, M.D.<br>Acting Asst. Chief Medical Officer. |

V A FORM APR 1946 7522 TEST FORM SUPERSEDES 2639, 2661, 2663, 2590, 2557, 2513

As the designated physician in the case, your REPORT OF TREATMENTS RENDERED must be filled out and returned to the Veterans Administration on Form 2690 as follows:

VETERANS ADMINISTRATION
Medical Form 2690a
Rev. Sept. 1938

## REPORT OF TREATMENTS RENDERED

Chicago, Illinois (Place) July 31, 1946 (Date)

To CHIEF MEDICAL OFFICER,
366 W. Adams Street
~~Chicago, Illinois~~ (Location of office)

JONES, John D. (Name of beneficiary) 3 397 399 79 (C-number)
1400 River Road (Address of beneficiary)

I report that treatment authorized was rendered the above-named beneficiary, during the period from 7/23/46 to 7/31/46, as follows:

| DATE | H | O | COMPLAINTS | CLINICAL FINDINGS | TREATMENT |
|---|---|---|---|---|---|
| 7/23 | | x | Chills & fever | Temperature 103 | Quinine Sulfate |
| 7/24 | | x | Chills & fever | Temperature 100 | Quinine Sulfate |
| 7/26 | | x | Chills & fever | Temperature 100 | Quinine Sulfate |

15—986

DIAGNOSIS:

Hospitalization (~~is~~) (is not) indicated at this time.
His condition is (~~stationary~~) (progressive) (~~improved~~).

Additional treatment during August (Period of time) (is) (~~is not~~) indicated.

JOSEPH DOE, M.D. (Signature of physician)

I was treated by Dr. ..... on the following date or dates:
(After each treatment the date thereof will be inserted and the beneficiary will acknowledge same by his signature. Use space on back of form, if necessary)

*Date* *Signature of Beneficiary* *Date* *Signature of Beneficiary*

(SIGNATURES ARE NOT NECESSARY)

At the present time if a veteran is on continuous treatment, request form 2690 should be mailed in to the Veterans' Administration on the 23 of each month if it is anticipated that treatment will be required during the following month. This is necessary in order that the authority may be in your possession at the beginning of the calendar month. Authority to render treatment CANNOT BE ISSUED EXCEPT FOR THE CALENDAR MONTH AND MUST BE RENEWED EACH MONTH.

The reverse side of Form 2690 should be used, in the simplified form, for the renewals, as follows:

---

II. REQUEST TO CONTINUE TREATMENT

Your authorization for treatment of the *(beneficiary) (beneficiaries) named below *(expires) (expired) July 31, 1946. I recommend the following additional treatments:

| Names | C-No. | Visits H | Visits O |
|---|---|---|---|
| | | | 2 |
| JONES, John D. | 3 397 399 79 | | |

*Delete inapplicable words

Joseph Doe, M.D.

---

As the attending physician for John D. Jones, your statement for his care should be submitted to the Veterans'Administration at the end of the month for the authorized care as follows: SUBMIT BILL IN DUPLICATE.

---

Chicago, Illinois, July 31, 1946

Veterans Administration
366 West Adams Street, Chicago, Illinois

Joseph Doe, M.D.
1000 Blank Strect
Chicago, Illinois

---

For Professional Services:

John D. Jones, C-No. 3 397 399 79

Three office treatments for Malaria rendered on July 23, 24, 26.....$6.00

---

*Odds and Ends of Information.* — If the examination to be given a veteran is for pension purposes, a brief summary on Form 2507-a will be furnished you by the Veterans' Administration. This examination is for rating purposes and a report is to be made on Form 2545 which will be furnished you for that purpose. Only one copy is to be submitted.

If a $3.00 routine office examination is authorized as covered in Item 21 of the Fee Schedule approved by the Illinois State Medical Society and the Veterans Administration, the report may be in narrative form. If treatment is then recommended, the nature of the proposed therapy should be explained in detail as well as the number of treatments that will probably be required and whether these treatments will be office calls or home visits.

It is to be stressed that *Service-Connection is determined solely by the adjudication of the Veterans Administration.*

Veterans receiving VOCATIONAL TRAINING UNDER PUBLIC 16, 78th Congress, may be furnished treatment for any condition medically determined necessary to prevent interruption of his training.

Veterans receiving VOCATIONAL TRAINING UNDER PUBLIC 346 may be treated for SERVICE-CONNECTED DISABILITIES ONLY.

If a veteran is known to have a disciplinary discharge from a veterans hospital within ninety days, it should be reported, as that may affect his eligibility for out-patient treatment.

DESIGNATED PHYSICIANS MAY RECEIVE REQUESTS FOR HOSPITALIZATION FROM THE VETERAN OR HIS REPRESENTATIVE. IN PROCESSING THESE REQUESTS THE PHYSICIAN MAY CONTACT THE VETERANS' ADMINISTRATION FOR APPROVAL BY WIRE OR BY TELEPHONE, OR BY USE OF THE FORMS AS EXPLAINED BEFORE.

Don't forget that authorizations to furnish treatment are specific and *expire at the end of the calendar month.* An authority for an office treatment does not permit a billing for a home visit. If the veteran is unable to report to the physician's office another request will be required for the home visit.

The Veterans' Administration will issue all authorities in accordance with the approved fee schedule. When a designated physician believes that the veteran is in need of a specific type of therapy which warrants a fee in excess of the schedule, full details must be furnished. Consideration will be given to such requests, provid-

ing the fees indicated are not in excess of those normally charged to the general public.

The Advisory Committee set up by the State Medical Society will review these cases and cooperate with the physician and the Veterans Administration in determining a fair and adequate payment.

---

We have asked for the cooperation of all members of the Illinois State Medical Society in order to provide the type of medical care our veterans should receive — at home, and by the physician of individual choice.

A constructive step forward can be taken by the medical profesion, and an actual contribution made by each physician toward the integrity and maintenance of the age old traditions in medicine — the physician-patient relationship we have so long maintained.

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## ILLINOIS STUDY OF CHILD HEALTH SERVICES: ORGANIZATION AND METHODS

Wars, as a rule, produce only few constructive results. One benificial effect of our recent war experience is the stimulation of interest in the health and fitness of our children. The rejection of many young men and women as unfit for service with the armed forces, serves as a measure of the general fitness of our young people. Many of these rejectees had remediable handicaps and diseases for which they had not sought medical care from the profession. This situation along with proposed legislation for medical care prompted the American Academy of Pediatrics in November 1944 to adopt the following objective; "To make available to all mothers and children of the U. S. all essential preventive, diagnostic and curative medical services of high quality, which used in cooperation with other services for children will make this country an ideal place for children to grow into responsible citizens." The Academy recognizes that the planning for medical care, unquestionably must rest on the physicians themselves. As physicians, we know what constitutes good medical care and we are largely responsible for providing that care. The pediatricians and general practitioners, as well as many other groups and individuals, are aware of the fact that if our children are to receive the care they need in the post-war period, sound and systematic planning must take place.

Unfortunately, data needed as a basis for this planning are incomplete, scattered and in some fields, almost totaly lacking. For this reason the Academy has initiated the job of obtaining the needed information and has requested the assistance of all practicing physicians and dentists, as well as the assistance of all organizations, caring for children. The Academy Study is being conducted through established channels of organized medicine and allied groups. This is the first step then to achieve the stated objective. Preliminary announcement of the Illinois Study of Child Health Services has been made in this journal.[1]

The second step will be the use of the tabulated study data by county and local Study Chairman from County and Branch Medical Societies with local representatives from other professional, service and lay organizations. After reviewing this data the local Study Chairman and his Study Committee are asked to formulate their recommendations for any desirable expansion of their local child health services. These recommendations will be forwarded to the Illinois Study Committee, which has been appointed by the Illinois State Medical Society and the Illinois State Dental Society. The final recommendations of the Illinois Study Committee will in turn be sent to the American Academy of Pediatrics and to the Illinois Study Advisory Committee to implement feasible recommendations.

The Illinois Study has been set up, therefore, so that ways will be established not only to obtain necessary comprehensive data in step one, but to use such data in step two as a realistic and sound basis for feasible expansion of child health services.

The degree of success in achieving the objective rests not only upon the pediatricians but upon the cooperation of all other professional service and lay groups at each level. This coordination of effort calls for strong and sustained medical leadership. It calls for an acceptable approach in community relationships and in the use of the proper group methods in this leadership. It calls for application of the Golden Rule as well as the application of the Baconian scientific principles. Effective community

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1. Ill. Med. Jl., Vol. 90, Aug., 1946.

planning for child health care consists in having representation of all interested groups at each level. At the proper time then, the scientific method can be applied to the problem as follows: joint participation in collecting the initial data, in analyzing the final, tabulated data; in making desirable recommendations on the basis of the previous two steps; and finally in carrying out feasible recommendations.

The organization and relationship of the several units in the Illinois Study of Child Health Services and routings of the several phases of the Study are presented in Chart 1.

Phase I. (———) Represents the initiation and conduct of the Study from the Academy to the Central Study Office in informing the State of the Study and in collecting the raw data from all concerned. Units 1, 2, 3, 4, 5, 6, 7.

Phase II. (.....) Represents routings of completed, final data from the Central Study Office to the local communities for their analysis. Units 7, 6, 2, 3, 4, 5.

Phase III. (—.—.—.) Represents the routings of local recommendations for desirable expansion of their child health services to the Study Committee. Units 5, 4, 3, 2, 1.

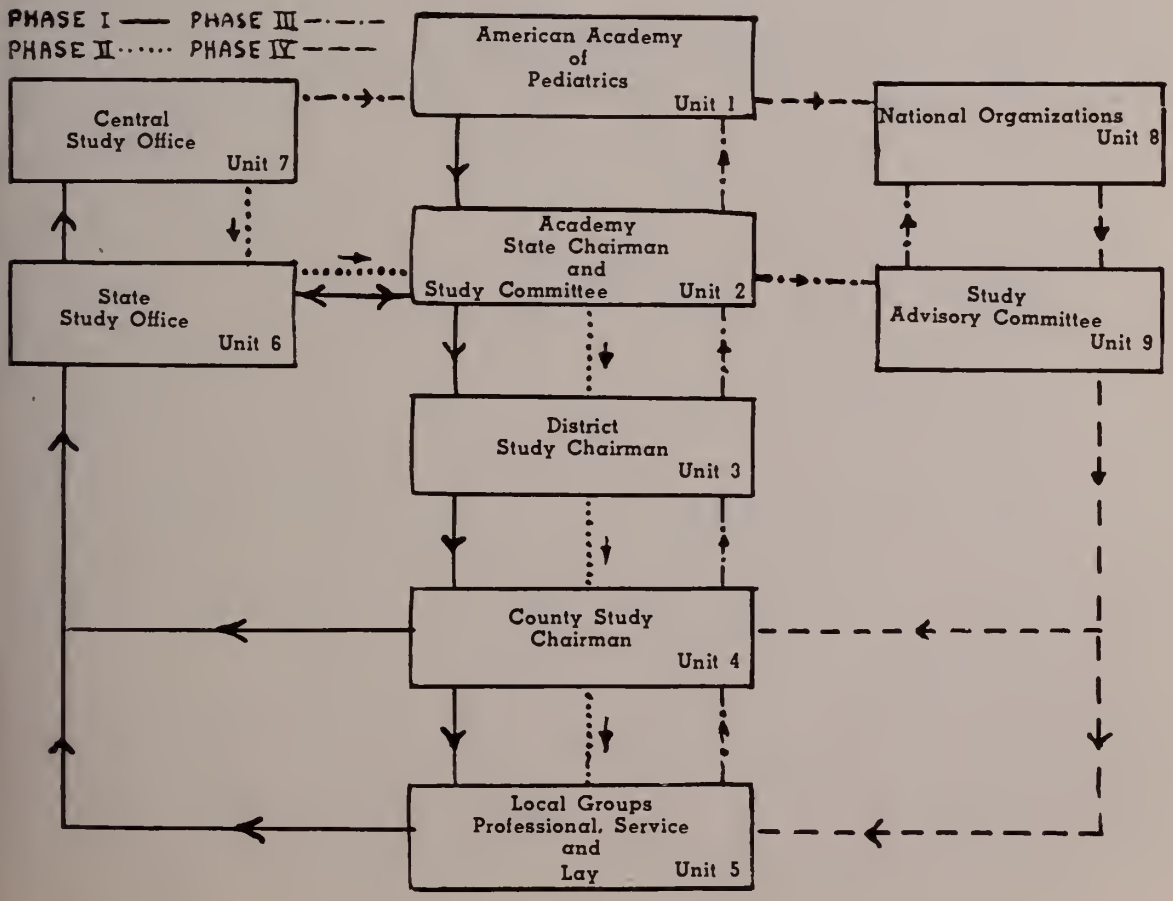
Phase IV. (— — — —) Represents the routings of action taken to implement feasible recommendations. Unit 1, 8, 9, 4, 5.

The functions of the various units in the organization of the Illinois Study are as follows:

a) Academy State Chairman and Study Committee. ( Unit 2 )
   1. Initiates the Study.
   2. Supervises the Study.
   3. Makes Study policies.
   4. Makes recommendations at State level.

b) Study Advisory Committee. ( Unit 9 )
   1. Interpret and publicize the Study.
   2. Coordinate activities of the local units of each organization with the County Study Chairman.
   3. Implement recommendations of the Study Committee.

CHART 1



c) State Study Office. ( Unit 6 )
   1. Initiate and organize the Study in the State.
   2. Interpret and publicize the Study
   3. Distribute, collect, check and forward to the Central Office, all schedules for tabulation.
   4. Obtain data on Series I schedules.
   5. Forward tabulated statistics to local Study Chairman and communities.
   6. Collect local recommendations from local Study Chairmen and communities, and forward to Study Committee.
   7. Make State Study report.

d) District Study Chairman. ( Unit 3 )
   1. Appoint County, Branch Society and local Study Chairmen.
   2. Interpret and publicize the Study to local Study Chairmen and various groups.
   3. Assist in coordinating the Study in the District.

e) County, Branch Society and Local Chairmen. ( Unit 4 )
   1. Interpret and publicize the Study
   2. Obtain cooperation with local professional, service and lay groups in obtaining comprehensive data.
   3. Coordinate Study activities with professional and service groups and work closely with local Health Officer and check Series II schedules with him.
   4. Cooperate with the State Study Office in follow-up activities for completion and return of all schedules.
   5. Coordinate local analysis of completed, final tabulated data by participating local groups.
   6. Forward joint recommendations of local participating groups to the Study Committee.
   7. Assist in implementing recommendations.

f) Local Groups: Professional, Service and Lay. (Unit 5)
   1. Complete and return all schedules.
   2. Evaluate jointly, completed final tabulated data with the County or local Study Chairman.
   3. Make joint recommendations for desirable expansion of child health services.
   4. Assist in implementing final recommendations that are feasible.

The following Study methods were devised by the Central Study Office and were tested and adjusted during the pilot study in North Carolina in 1945.

Field workers of the Illinois Study office are responsible for collecting data from all hospitals, sanatoriums and related institutions. These Series I schedules are as follows: I-A. (Information on pediatric hospitals, general hospitals and other hospitals with maternity facilities.) I-D. (Supplementary information on General, Pediatric and Maternity Hospitals with 25 or more beds.) I-E. (Nervous and Mental Hospitals, Including Institutions for Feeble-minded.) I-F. (Tuberculosis Hospitals; Sanatoriums and Preventoriums admitting Tubercular Patients.) I-G. Convalescent and Chronic Hospitals, Rest Homes and Nursing Homes.) I-H. Contagious Disease Hospitals) I-J. (Orthopedic Hospitals).

Pediatricians or other qualified physicians are responsible for visiting assigned hospitals to obtain information on Schedule I-D. As far as possible pediatricians will be assigned to hospitals where they are not staff members so as to obtain the most objective evaluation possible. Schedule I-D. will, when completed, be sent by pediatricians to the State Study Office.

Health Officers of local health jurisdictions are asked to complete Schedule II, (Summary of Community Services.) and to distribute and collect from all officials and voluntary community agencies, the completed following Schedules: II-A. (Medical well-child Conferences); II-B. (Dental Services for Children); II-C. (Mental hygiene services for children); II-D. (Health services for physically handicapped children); II-E. (Communicable disease control); II-F. (School health services); II-G. (Public health nursing services). The local health officer is asked to check Series II Schedules with the local Study Chairman and then forward them to the State office.

The State Study Office will mail Series III Schedules directly to physicians, pediatricians and dentists with an enclosed self-addressed, stamped envelope. Each physician and dentist is asked to contribute his share by completing his one page schedule and returning the schedule

to the Study Office. It is realized that due to present unsettled conditions or errors, some physicians will not appear on our mailing list. Any physician who does not receive a schedule, is urgently requested to contact the Illinois Study of Child Health Services, 1465 Sherman Ave., Evanston, Ill.

Physicians and dentists who will receive schedule III-A (Physicians in private practice) and III-C (Dentists in private practice) respectively are asked to indicate their data only for the day stamped on each schedule. This one-day record question is asked for the specific purpose of determining how many physcians and dentists care for how many children in a given area. It is a means of determining the case-loads of physicians and dentists in a specific area. It is *not* being asked in order to determine the size of the practice of individual physicians and dentists, but rather to determine the over-all picture of medical activities in one area, over a representative period of time. If each doctor or dentist were left to choose the one day on which he wished to report, the chances are, human nature being what it is, he would choose his busiest day.

The result would obviously not be a true picture of the normal amount of medical and dental service rendered. Therefore, in order to take into account the atypical as well as the typical days, each physician and dentist is asked to report for a specified day. Thus, supposing that there are 700 doctors practicing in a certain city, when the questionnaires are sent out, 100 of them marked "Monday", another 100 "Tuesday", and so on throughout the whole week, by this method we have 1/7 of all the physicians and dentists reporting for each day of the week. The indentity of any one man becomes lost in the over-all picture, so that Dr. Z. who is asked to report on Wednesday, which happens to be the day he is attending a meeting, need not be concerned that the day specified is not typical of his practice. Emphasis is placed on the fact that the Study procedures for collecting data are so arranged that the indentities of the individuals are lost.

The organization and methods here portrayed for the Illinois Study of Child Health Services indicate the magnitude of the task the Academy has initiated and the importance of this work to all professional, service and lay organizations, as well as to every individual in the State. If changes in the medical care of children are desirable, such changes can best be established in an evolutionary way using familiar and established, democratic and scientific principles in effecting such changes. The Academy and this Society asks for and expects your wholehearted cooperation.

## ARMY PHYSICAL RECORDS POINT TO DANGER OF OVERWEIGHT

Overweight, emotional elevations of the blood pressure and acceleration of the heart beat are the forerunners of serious illness, according to four investigators writing in the July 20 issue of *The Journal of the American Medical Association.*

The investigators, Robert L. Levy, M.D., of New York, Paul D. White, M.D., of Boston, William D. Stroud, M.D., of Philadelphia and Brig. Gen. Charles C. Hillman, United States Army, studied the medical records of 22,741 army officers which contained the results of annual physical examinations made between January 1924 and December 1941.

The authors predict from their study that overweight associated with the temporary elevations of blood pressure and rapid heart beat will lead eventually to the development of high blood pressure and diseases involving the heart, blood vessels and kidneys.

A group of men who during the period of study showed none of the predisposing factors were observed in comparison. The study reveals that the later development of high blood pressure was 12 times as great in the overweight group as in the comparison group. In the case of retirement from duty because of diseases involving the heart, blood vessels and kidneys, the rate was four times as great.

# State Department of Public Health

## NEW WEAPONS IN TUBERCULOSIS CONTROL

Fifty-one years ago x-ray was a new discovery, limited in efficiency, but abounding in potentialities in the medical field. Today, in the form of mobile x-ray units, this device is now being used by the State of Illinois as a very practical means of finding tuberculosis in its early stages.

On January 10, 1946, the State Department of Public Health accepted delivery of the first of four mobile x-ray units. The second was delivered in February and two more will be forthcoming within the near future. Each of these units, designed for mass x-raying of chests, is in effect a complete x-ray laboratory mounted on a 1½ ton truck. Electrical power is provided by trailer generators which enable them to operate in the most remote areas of the State. The photo-roentgen equipment produces 4 x 5 inch films and is capable of taking 200 to 300 pictures a day; serious consideration is now being given to changing the film to a 70 mm. type which will increase the capacity of these units even beyond this point. "On the spot" development of films is made possible by the inclusion of water tanks and a dark room in the construction of these mobile laboratories.

Under the administration of the Division of Tuberculosis Control, the operation of each unit requires a staff of four individuals — a public health nurse in charge, an x-ray technician, a clerk and a maintenance operator. Coordination of the activities of all units is accomplished through periodic staff meetings at Division headquarters.

The acquisition of this technical equipment, we believe, is a preliminary, forward step in the development of a much needed, long range tuberculosis control program. It is true that experience in Illinois during the past 45 years has paralleled to some degree that of other areas as shown by the 70% decrease in tuberculosis mortality. Gratifying as this may be, this reduction has not been as rapid as for the entire country in which a 75% reduction has taken place. Even more significant, our decline has not been as rapid here as in several states where the problems of control are considerably more complex. Massachusetts, for example, with the most highly urbanized population in the country reports a 41% reduction in the tuberculosis death rate between 1930 and 1940. New York with 35%, Pennsylvania with 31%, New Jersey with 36% and California with 45% are some of a fairly large group of states where a more favorable situation exists. The reduction in Illinois during that time amounted to only 26%.

The term, "preliminary step," in the foregoing paragraph is significant, for a modern tuberculosis control program includes other measures of equal importance. Adequate treatment facilities, vocational rehabilitation during convalescence and aid to families of wage earners stricken with the disease are problems directly affecting a successful program. As to the first, it is estimated that 2800 more beds are needed in Illinois to provide adequate treatment facilities. This problem was solved in part by the 64th General Assembly which appropriated $4,000,000 for the construction of several State sanatoria. Progress has already been made as to the selection of strategic sites for these institutions. It is hoped that within the next two or three years their construction will near comple-

tion. The questions concerning vocational rehabilitation and aid to wage earners' families are as yet unanswered but certainly these problems are not impossible of solution. Again we look with hope to the future.

Sound as these other measures are, however, their success will depend upon an active and extensive case finding program which will discover tuberculosis in its minimal stages — *then* is when treatment is effective; *then* is when the individual's rehabilitation program can be initiated early; *then* is when the loss of wages will be the least; *then is when isolation can best prevent spread.* Mass x-rays among the population, therefore, is the first and most logical project that must be developed if the symptomless, early cases are to be discovered. The mobile x-ray units were acquired for just this purpose.

The Department has already received numerous requests for x-ray surveys from various organizations. Efforts are being made to group such requests so that in a given county all of them may be fulfilled at one time by a county-wide x-ray survey. Consequently, agencies requesting the facilities of the mobile x-ray units are urged to use the following suggestions:

1. Any individual or organization may initiate a request for a mass x-ray survey program.
2. Requests for the use of the mobile x-ray units of the Department of Public Health should be made through the full-time city, county, or district health officer.
3. Other local organizations, industries, etc., should be contacted early in the planning so that the approximate number of persons to be x-rayed will be known in advance and the dates for the unit scheduled accordingly.
4. Upon receiving a request the Health Officer would plan jointly with the Tuberculosis Association, the sanitarium board, and the local Medical Society to insure complete understanding of the responsibilities involved.
5. An assurance of at least 4,000 or 20% of the adult population in the county should be had before forwarding the request to the Division of Tuberculosis Control. (A minimum of 20% of the adult population seems necessary as an adequate control measure.)
6. Provisions for rechecks of designated persons at needed intervals and hospitalization if indicated should be made locally.
7. The eligible group for x-ray will include any positive reactors to the tuberculin test among high school students and the entire adult population. (Children under 15 are not routinely x-rayed.)
8. A publicity campaign is essential to the success of the survey. Publicity materials such as posters and pamphlets available from the Department of Public Health may be secured through the county or district health officer. It is suggested that additional materials be developed locally to be used in the health education program preceding the x-raying. All publicity should be approved by a committee representing the cooperating agencies.
9. Certain essential facts concerning the program bear emphasis:
   a. X-ray takes only a minute.
   b. X-ray can be done with clothes on.
   c. A report is sent directly to the individual.

Following the reading of films, individuals with negative findings are informed of these results by printed cards mailed to their residences. Persons whose films show evidences of tuberculosis or other pathology are requested by letter to visit their family physicians. The findings and even films will be mailed to the physician upon written request and the patient's consent. This procedure, of course, will not insure that all in need of medical attention will seek the proper advice. Because of this, a follow-up service must be arranged through some agency — the Sanitarium Board, the Tuberculosis Association or the Local Health Department. The trained representatives of these groups can do much to educate and persuade the ignorant, the fearful and the hesitant to see the benefits of further observation.

Thus a new weapon, the mobile x-ray unit, has been brought into the fight against tuberculosis. Added to the facilities and the interested workers already engaged in that fight, the fifty-one year old invention, now on wheels, can do much to help the many who are unknowingly infected. Equally important, it will uncover those who are innocently spreading the disease. By its use we in Illinois hope that the downward course in tuberculosis case and death rates can be hastened. Our place should be among the leading, not the lagging, states.



# Correspondence

## CLINICAL CONGRESS, AMERICAN COLLEGE OF SURGEONS, SCHEDULED FOR CLEVELAND, DECEMBER 16-20

The thirty-second Clinical Congress of the American College of Surgeons, originally scheduled for New York from September 9 to 13 but postponed because of overlapping with the United Nations Assembly, will be held in Cleveland, with headquarters at the Cleveland Public Auditorium, from December 16 to 20. This will be the first annual meeting of the College since November, 1941.

The opening session of the Congress in Cleveland will be the Hospital Standardization Conference on Monday morning, December 16, at 10 o'clock, at which Dr. W. Edward Gallie of Toronto, President of the College, will preside. Talks by medical and hospital authorities on advances in medicine and surgery as they affect the postwar hospital will be given. The hospital conferences will continue each morning and afternoon through Thursday, with evening sessions on Tuesday and Wednesday.

Panel discussions on the following subjects are planned for afternoons from Monday through Friday: Rehabilitation of the Surgical Patient and Early Ambulation; Treatment of Cancer of the large bowel; Thiouracil in Thyroid Disease; Recent Trends in Management of Carcinoma of the Cervix; Anesthesia; Protein Metabolism in the Surgical Patient; Spinal Cord Injuries; Surgery of the Stomach; Surgery of the Vascular System. Some of the panels will begin at 1:30; the others at 3:30 o'clock.

Panel discussions in the field of Ophthalmology will be held at 11:00 o'clock Tuesday through Thursday mornings on the following subjects: Tuesday, Retinal Detachment; Wednesday, Glaucoma; Thursday, Keratoplasty. Panel discussions in the field of Otorhinolaryngology will be held at 11:00 o'clock Tuesday through Thursday mornings on the following subjects: Tuesday, Treatment of Menier's Syndrome; Wednesday, Osteomyelitis of the Skull; Thursday, Rehabilitation of War Deafness.

Forums on Fundamental Surgical Problems will be conducted Tuesday through Friday mornings. The purpose of these forums is to present the best that is new in surgery. Dr. Owen H. Wangesteen of Minneapolis is chairman of the committee in charge.

A Symposium on Fractures and other Traumas will be held on Tuesday afternoon and a Symposium on Cancer on Wednesday afternoon. On Friday afternoon concurrent specialty panels are planned in the following fields: Orthopedic Surgery; Urology; Plastic Surgery; Neurological Surgery; Obstetrics; and Thoracic Surgery.

Also to be held daily throughout the Congress will be operative and nonoperative clinics and demonstrations in local hospitals.

The evening program will begin with the Presidental Meeting on Monday night. Three concurrent symposia will be held on Tuesday night on the following subjects: Care of the Patient before and after Operation; Orbital Reconstruction Including Prosthesis; and "Treatment of Deafness." Two concurrent symposia will be conducted on Wednesday night on the following subjects: Venous Thrombosis and Prevention of Pulmonary Embolism; Plastic Surgery of the Head and Neck. Three concurrent symposia will be held on Thursday night on the following subjects: Antibiotic and Chemotherapeutic Agents in Surgery; Ophthalmology (three

subjects); and Surgery of the Nasal Accessory Sinuses.

The concluding event of the Congress will be the Convocation on Friday night at which fellowships will be conferred upon candidates. The incoming president, Dr. Irvin Abell of Louisville, will preside. The number figuring in this ceremony will be much larger than usual owing to the fact that several hundred surgeons who were received into fellowship in absentia during the years in which no Convocation was held, will participate in the initiation ceremonies, in addition to the candidates of the current year. A large proportion of the new fellows are World War II veterans.

Annual meetings of Governors and Fellows will be held during the Congress. Other important features will be showings of medical motion pictures and extensive technical and educational exhibits.

## NEW CHAIRMAN AT N. U. DEPT. OF PATHOLOGY

Dr. William B. Wartman, who served as a lieutenant colonel in the U.S. Army Medical corps during the war, has been appointed Morrison Professor of Pathology and chairman of that department in the Medical school of Northwestern University.

Dr. Wartman served on the staff of Western Reserve University from 1935-41, becoming pathologist in charge at the University hospitals in 1939. He was resident pathologist at the University of Pennsylvania hospitals from 1936-39.

A graduate of the University of Pennsylvania, he received the B.S. degree in 1929 and the M.D. degree in 1932 and served his internship at Lankenau hospital, Philadelphia.

## TWO GROUPS JOIN FOR TUBERCULOSIS PROGRAM

A meeting of the Chicago Tuberculosis Society and the Illinois Chapter of the American College of Chest Physicians will be held Thursday, October 24, 1946 at the Bismark Hotel. Dinner will be served at 6:30 P.M. Election of Officers will be held. The Scientific Program will include a talk by Dr. Jay Arthur Myers of the University of Minneapolis. His subject will be, "Early Tuberculosis".

## EDSON P. LICHTY MADE EXECUTIVE DIRECTOR OF CHICAGO BLUE CROSS PLAN

Edson P. Lichty, who has served as assistant director in charge of enrollment of the Blue Cross Plan for Hospital Care in Chicago, since September, 1944, has just been elected executive director of that Plan.

Mr. Lichty is well qualified for his new post and has been in Blue Cross work during much of his business career. He resigned as director of Hospital Service, Inc., of Iowa, to come to the Chicago Plan. He had worked with the Iowa Plan from its inception in November, 1939. Previous to his assisting in the establishment of Blue Cross in Iowa, he was in charge of enrollment with the Associated Hospital Service of New York.

A fact which is not in dispute is that people intimately exposed to tuberculosis infection develop lung tuberculosis more frequently than those who are not so exposed. There is in this fact strong presumptive evidence for the belief that it is fresh infection from without which in many people is responsible for the final lung disease. Recent pathological studies have shown that many of the adult apical and sub-apical infections are in fact of exogenous origin. Whether an exogenous infection acts directly or by causing a breakdown of an old lung deposit is of academic interest only. What is of importance is that the sputum positive person is a danger to all ages and that no immunity in young people will stand repeated re-infections. Charles Cameron, M.D., NAPT Bull., Feb. 1946.

# Original Articles

## WAR AND DISEASE

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Disease is one of the primary fates in shaping men's lives. Man, from the day of his birth to the day of his death, either battles disease by trying to prevent it, or, if unsuccessful in this, by trying to conquer it when it appears. Nations, which are aggregates of men, constantly carry on the same struggle. Disease has determined the migration of races, their colonial expansion, their geographical distribution. It has conquered armies, overthrown empires and changed the course of history. Historians, obsessed with the study of economic conditions, the growth of ideologies, the magic of gifted orators and the skill of military commanders, have often neglected completely the important role of epidemics and the effects of national malnutrition.

In times of peace, as well as of war, great epidemics have left their mark upon the history of states. The cause of the fall of the Roman Empire has engaged the attention of historians since the days of Gibbon. Many theories have been suggested and the causes probably were numerous. We are certain that two diseases, malaria and smallpox, played major roles in contributing to the downfall of that powerful empire.

At the beginning of the second century before Christ, malaria had spread far and wide throughout Italy. In some way Rome, however, had remained free from it. Cicero gave as a reason for this the foresight of Romulus, who built his city in a healthy location on the hills. A broader reason, however, is found in the sanitary arrangements of ancient Rome. The early settlers in Rome had built their homes on hills but also promptly drained the valleys, which were marshy. In the sixth century B.C., they built the famous Cloaca Maxima or Great Sewer, which not only kept the lowlands effectually drained but also carried off the sewage from the city. Twenty-seven centuries later, the Romans were still using it, although some supposedly modern American cities allowed their refuse to run in the street gutters.

Although Rome remained free of malaria, the neighboring countryside was not so fortunate. The poor peasant toiling in the Campagna, a region close to Rome, knew that after his day's labor was over, he was going home to have a chill. Many days he was too ill to work and his crops were not cared for. To add to his troubles there were wars and his fields were laid waste. The countryside lost its charm for the peasant. He left his plow in the furrow, turned his back on the fields, packed his belongings on his ox-cart and drove to Rome — not because of high wages and short hours, but to escape fever and famine.

This mass migration to the city led to congestion, idleness, sloth, corruption and vice. The rabble grew steadily and cried for "panem et circenses" (bread and circuses), following eagerly any demogogue who would promise them ease and comfort without work. The principle of dispossessing the thrifty and prosperous, whether by taxation or by plunder, became the popular crusade. Both Julius Caesar and Mark Antony

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Oration in Medicine, Illinois State Medical Society, May 14, 1946, Chicago.

knew well how to strike this popular chord. This rabble, which grew in numbers and in power, played a dominating role in the dissolution of Rome. And malaria had had a powerful influence in producing the rabble.

With the return of the victorius Roman army from Mesopotamia, a new and frightful pestilence appeared in the capital city. Marcus Aurelius Antoninus was then emperor, and the pestilence has been called by historians the Antonine Plague. The illustrious Galen was practising in Rome at the time and has left us an excellent description of the disease. Galen writes that the first symptom of the disease was a foul breath, then high fever and delirium. Presently a skin eruption appeared, consisting mainly of pustules, which soon were covered with scabs, giving the patient an aspect both terrifying and loathsome. Most physicians, I think, on reading this account, will agree that the disease Galen described was smallpox.

The toll in Rome was enormous. All day long, wagons, piled high with the dead, rattled over the cobble stones, while the streets themselves were filled with dead bodies and staggering, dying patients. The pestilence spread throughout all Italy and, according to Paulus Orosius, the country was so devastated that towns were left without inhabitants, and the fields, through lack of cultivation, became wildernesses. The army, confined to their barracks, suffered even more than the civilian population. Entire legions perished almost to the man.

In the midst of these calamities, the Germanic tribes invaded. Marcus Aurelius was obliged to raise a new army to meet the peril. Slaves and gladiators were drafted into the army, and new volunteers appeared from the outlying provinces. In Rome itself, no volunteers could be found, and the lazy, shiftless rabble hooted the gladiators as they marched away, complaining that the Emperor was robbing them of their pleasures.

This time Marcus Aurelius accomplished the seemingly impossible and drove the Germans out. But two years later the Teutonic tribes appeared again. Marcus Aurelius hastened to Vindobona, the modern Vienna, to meet the invaders. Here the great emperor himself was struck down by the pestilence. The great empire, leaderless against both disease and invaders, tottered to its fall.

It would be very interesting to speculate on the course of Roman history and of world history if Rome had known that quinine could check malaria or that vaccination would prevent smallpox.

As disease played such a role in the fall of Rome, so the fall of the Venetian Republic was caused quite as much by the constant incursions of bubonic plague as by the armed attacks of her warlike neighbors. A maritime state, her ships carried wares to and from the Levant, bringing back, as excess cargo, rats and bubonic plague. In 1629 Venice had a total population of 142,804; two years later an epidemic of plague took a toll of 94,136. This epidemic of 1631 was the last great visitation of the plague. The grateful city built as a thank offering for her deliverance the beautiful church of Santa Maria della Salute, which every visitor sees on the Grand Canal. Also, further down the canal, one sees the Church of St. Roch, built to receive the body of St. Roch, the plague saint, which had been carried off by stealth from Montpellier in 1485. Indeed, Venice shows in both art and architecture how closely her history is interwoven with that of bubonic plague.

In England the Black Death produced as great a revolution in the social and economic life of Britain as all the wars that hardy island has waged. The terrific toll the plague took among priests and higher ecclesiastics necessitated the filling of these depleted ranks by ill-trained and often ignorant peasants. These new priests had little respect for the prerogatives of the clergy but more concern for the lot of the common people from whence they had but recently come and with whom they had their closest ties. They were more interested in the problems of their own people than in the problems of Rome. As a result of this attitude they had a powerful influence upon the English Reformation.

But we do not have to go to Europe for examples of the role disease plays in history. On our own continent, such history repeats itself. There is no more fascinating puzzle in the history of the past then the puzzle of the Mayas. Here was a people whose ruined cities in Yucatan

and Guatemala reveal a race who were builders of large cities with enormous palaces and huge temples, as well as versed in agriculture, in the art of pottery-making, and in working with silver and wood. But even more astonishing than these was their knowledge of astronomy and their calculations of time. While the English speaking people of the past century believed mostly with Archbishop Ussher that the day of creation was 4004 B.C., the Mayans believed the world was millions of years old and that man first appeared on this earth several hundred thousand years ago. This ancient Mayan civilization bloomed, flowered and faded long before the arrival of Cortez.

The Mayans, according to their ancient chronicles, suffered from frequent epidemics of what they called "the black vomit", which has been identified with yellow fever. A very severe epidemic in 1454 nearly destroyed the race. The epidemics continued and the Mayans finally abandoned their cities and scattered over the country, seeking especially the highlands, which seemed free of this disease that infested the lowlands and especially the swampy land near the sea.

When Columbus landed at Hispaniola, the modern Haiti, in 1492, yellow fever was lurking on the island waiting for the Spaniards. Historians who accompanied Columbus on this second voyage to America write of a strange malady which attacked the Spaniards at Hispaniola and that "the sick became so yellow that they looked as if they had been tinted with a saffron dye". In 1502, the Spanish explorer, De Lares, landed at Hispaniola with 2500 men. In a few weeks more than 1000 had died of the strange yellow malady.

The Spaniards compelled the native Indians to slave in the gold mines and plantations. From 1508 to 1514, the number of inhabitants on the island fell from 60,000 to 14,000. The Spaniards then introduced African slaves to work on the island. The negroes, in spite of the physical hardships, lived, multiplied and soon outnumbered the whites and Indians. A century later, Hispaniola was an island of blacks and has remained so until this day, when more than 90% of the people are pure blooded negroes. The negroes survived because of their hardier physique and also because of their relative immunity to yellow fever, a fact stressed by all writers from the earliest period to the present. So, thanks to yellow fever, Haiti is a black rather than a Spanish or Indian republic.

The story of the Panama Canal has been told many times. De Lesseps failed to build the canal not because he did not have the knowledge, the energy and the technical skill but because he could not conquer yellow fever. When de Lesseps first visited Panama, a French resident warned him "If you try to build this canal, there will not be trees enough on the isthmus to make crosses for the graves of your laborers." De Lesseps persisted and more than 20,000 white men perished — the natives and blacks were not counted. Gorgas, by stamping out the mosquito, accomplished the task in which de Lesseps had failed. If the French had succeeded, the canal would have become a French possession — a fact that certainly would have left its impress on American history the past half century.

Dramatic as are the changes produced by disease during times of peace, the effects of disease in times of war are even more cataclysmal. Wars spread disease, and disease, in turn, destroys warriors. Epidemics in past wars have only too often destroyed armies and left nothing behind but a melancholy account of their progress. In some wars, epidemics, although they have destroyed thousands, have left some clue that enables later generations to conquer or to prevent them. In other wars we have the melancholy picture of the deaths to thousands which could have been prevented by the intelligent application of measures even then already known to medical science. This picture, unfortunately, appears with distressing frequency as we turn the pages of medical history.

The great plague of Athens was one of the most dramatic episodes in the history of civilization. Whether this was bubonic plague, as Francis Adams of Banchory, who was not only an eminent physician but an outstanding Greek scholar, asserted, or whether it was typhus fever or scarlet fever as others maintain, is beside the point. The Athens of Pericles presented a level of culture and intelligence never equalled, before or since. Within the walls of this city of some two hundred thousand, lived and worked the dramatists Aeschylus, Sophocles, Euripides, and Aristophanes; the philosophers Plato, Xenophon, and Anaxagoras; the sculptors Phidias,

Praxiteles, and Polygnotus, and the historian Thucydides. When the Spartan king, Archidamus, attacked Athens, Pericles followed what is called today a "scorched earth" policy. He withdrew all his soldiers and people from the outlying country into the walled city of Athens for protection. Athens was soon choked with refugees. There were no houses for the newcomers, the food supply was cut off, the proper disposal of refuse became impossible, the water supply became contaminated. Then, like a thunderbolt, appeared the plague with all those horrors so graphically described by Thucydides, an eye witness of the harrowing scenes.

The Spartan king prudently withdrew and attacked elsewhere. He feared the epidemic might spread into his own army, and he also wisely reckoned that the plague would destroy more Athenians than could the Spartans. According to some authorities, the first wave of the epidemic destroyed one-third of the inhabitants of Athens; according to others, two-thirds. After the first wave had subsided somewhat, Pericles sent an expedition to capture Potidaea and harass the Spartans from the rear. This expedition, if successful, would have changed the entire course of the war. Unfortunately, the men carried the seeds of the pestilence with them and even before the ships reached Potidaea, the disease broke out among the soldiers and the fleet was compelled to return to Athens. Pericles then planned another brilliant stroke. He sailed with his troops to Epidaurus, hoping to capture that city and again strike the Spartans from the rear. This expedition was also a dismal failure because, according to Plutarch, "the distemper which prevailed in his army broke all his measures, for it not only carried off his own men, but all that had intercourse with them."

Athens slowly went to her doom. While she was disintegrating, the plague struck down Pericles himself and no leader of equal ability arose to take his place. Finally, the Spartan admiral, Lysander, sailed into the harbor of Piraeus; the Spartans tore down the long walls of Athens to the merry tune of Spartan flutes, the young Spartan women danced gaily to the music while the Athenians filled the air with wails and lamentations. The Athenian Empire was humbled to the dust, never to rise again. The plague of Athens had played a catastrophic part in her defeat, and had left no clue to prevent similar catastrophes.

Unfortunatey, the historians of the Peloponnesian War — the war between Athens and Sparta — were not medical men. If Hippocrates, as well as Thucydides, had described the plague of Athens, there would probably be no uncertainty concerning the nature of this epidemic. Fortunately, some of the epidemics accompanying later wars were described by army surgeons with such accuracy and fidelity that the diagnosis is certain.

Few wars in history have lasted so long or have been more destructive of life and property than the Thirty Years War. This war, which began as a struggle between Protestants and Catholics, became in time a war in which the Protestants of Germany and Sweden were allied with Richelieu, the great Catholic prelate, in the struggle against Catholic Austria. This war was a "total war" in the modern sense. Far more civilians — men, women and children — were destroyed than soldiers. Germany, according to some authorities, lost one-half of her entire population; according to others, two-thirds. A century and a half passed before the population of Germany reached its pre-war level.

The Thirty Years War is commonly divided by historians into the Bohemian period, the Palatine period, the Danish period, the Swedish period, and the French period. The medical historian, Prinzing, divides it into the typhus period and the plague period.

The disease which carried off so many victims in the early part of this war was the notorious Hungarian disease, a disease accurately described by Tobias Cober, who served as surgeon in the Army of Rudolf II, King of Hungary, in the wars against the Turks. He notes that the disease raged especially in camps heavily infested with lice, and his description leaves no doubt that it was typhus fever. Later in the war, after typhus had apparently spent its force, bubonic plague appeared.

Measures were taken by certain cities to prevent both pestilences from entering. In Munich, for instance, the city fathers shut the city's gates against all strangers, disinfected all incoming letters, and washed with vinegar all the money that came in. These measures stayed the hand of the plague for a time but presently, infected

Spanish soldiers forced their way into the city and spread the disease among the inhabitants. As a result, more than one-half the population died from the plague in a few months.

The Thirty Years War was also noteworthy for the unusual complexion of the contending armies. Each army had not only its soldiers but its women — the soldiers taking with them all possible comforts of home. If the soldier had a wife, he took her along. If she were unwilling to go or if he had no wife, he took a woman along. In addition to the soldiers, their women and children who were numerous and constantly arriving, there were traders, peddlers, gamblers, thieves, beggars, and priests. The traders had their eyes on the soldiers' booty, the gamblers were after their pay. Another interesting addition to these remarkable armies was the schoolmaster, who travelled with the army and held classes for the children.

The number of camp followers far exceeded that of the actual soldiers. General Gronsfeld, at the end of the war, reported to the Elector Maxmilian that the Bavarian army consisted of 40,000 soldiers and 140,000 women, children and camp followers. The Swedes, when they came down from the North with Gustavus Adolphus singing that fine old Lutheran hymn, "eine Feste Burg ist unser Gott", were at first appalled by the laxity that prevailed in the armies of their allies. But they, too, were "all too human" and at the end of the war four Swedish companies which revolted at Köthen consisted of 600 soldiers, 650 women and 900 illegitimate children!

It requires no imagination to picture the effect of these conditions upon the spread of venereal diseases throughout Central Europe.

Many great generals, among them Tilly, Wallenstein, and Gustavus Adolphus, perished in the course of the war. If the results of this war in terms of great victories, territory gained, and prestige enhanced, were balanced against the losses through pestilence, the real victors most certainly were typhus and plague.

Napoleon, the greatest military genius of the nineteenth century, was really defeated some time before Waterloo; he was defeated by his ill-starred campaign in Russia. The Grand Army, to quote Larrey, Napoleon's great surgeon, set out for Russia 400,000 strong. Six months later this army, retreating from Russia, finally reached Gumbinnen in East Prussia, numbering only 3,000!

This disastrous adventure of Napoleon has been described in every history of Europe. The bloody battles, the intense cold, the ferocity of the Russian Cossacks, have all been stressed as the cause of Napoleon's defeat. But the role played by disease was even more important. Typhus fever seems to have played the major role, ably assisted by typhoid and dysentery.

The accounts left by the surgeons in Napoleon's army give us a clear picture of the devastation caused by disease. One of the most dramatic was written by Kerkhoffs, a Dutch surgeon attached to the Third Army Corps of Marshall Ney. This Corps, Kerkhoffs relates, was finally reduced to twenty men, as the result of privation and disease. In discussing the failure of the campaign, Kerkhoffs remarked that if Napoleon had contented himself with occupying Poland and organizing sanitation there, the campaign would have succeeded and changed the whole course of history.

But Napoleon was in a hurry. In spite of bloody battles and the ever-increasing number of sick, he pressed on to Moscow, carrying wagon loads of infected soldiers into that city, leaving behind the desperately sick in towns and villages where they infected the new troops pressing on eastward.

Sergeant Bourgogne of the Grand Army wrote an interesting account of the march into Russia and was particularly impressed by the large number of vermin he saw. He went to sleep on a reed mat in a little town of Poland. Presently he awoke from his slumber and finding himself covered with lice, stripped off his shirt and trousers and threw them into the fire. There were so many of these animals on his garments that, as he relates, they "exploded like the fire of two ranks of infantry."

The role of lice in the production of typhus fever was not discovered until a century later. However, Napoleon's surgeons write so much about lice that we wonder if they did not suspect them. They were aware, however, that typhus was highly contagious. One surgeon observed that Yorck's Prussians, who had not been in Moscow at all, had no cases of typhus fever until they followed the retreating French. Another army

corps had no typhus until it passed along a road previously used by the French. After a march of fourteen miles on this road, there were fifteen to twenty men in each company ill from this disease.

Napoleon's disaster in Russia was not the first time he had been defeated by disease. His previous campaign in Syria had ended in retreat before an advancing epidemic of bubonic plague. On one dramatic occasion Napoleon mingled freely among the plague-infested soldiers at Jaffa to show his contempt for the disease while his own surgeon, Desgenettes, inoculated himself with pus from the buboe of a sick soldier to prove that the disease was not contagious. Desgenettes, fortunately for himself but unfortunately as a hygienic lesson, remained perfectly well, probably because, as we now know, the pus from plague boils often contains very few plague bacilli.

The ravages of typhus, typhoid, and dysentery did not cease with the end of Napoleon's Russian campaign. The retreating army scattered pestilence far and wide. Typhus fever broke out in East Prussia and caused the death of 20,000 inhabitants. From East Prussia it spread rapidly to other parts of Germany, to Silesia, Saxony, Bavaria, and the Rhineland. Prinzing estimates that 10 per cent of the population of Germany contracted typhus fever, and 200,000 to 300,000 died. From Germany it spread to France, where it also caused an appalling toll. In Metz, all the physicians contracted the disease and many of them died. In the Department of Moselle alone, more than 100,000 died from typhus, this figure not including soldiers.

Typhoid fever, long confused with typhus, has caused a greater number of deaths than typhus in the armies of nations whose hygienic standards have never tolerated lice.

In the American Civil War the Union Army lost 44,000 killed in battle while 186,000 died of disease. Of those who died of disease, 36,000 died of typhoid fever.

The health record of the American Army during the Spanish-American War gives us no cause for pride. During this minor struggle, sixty-seven officers and 1,872 men died of disease, and twenty-nine officers and 440 privates were killed in action. The death rate in the army camps became so high as to constitute a national scandal. A commission headed by Walter Reed was appointed to study sanitation in the army camps. They found that "more than ninety per cent of the volunteer regiments developed typhoid fever within eight weeks after they came into camp."

The report of this commission remains a monumental contribution to our knowledge of typhoid fever. They found that the most important carriers of the infection were flies, which feasted on the dejecta of patients and then crawled over the food in the mess halls. Ignorant, untrained hospital orderlies also spread the disease. Without even washing their hands, many of these orderlies left the hospital wards and walked into the mess hall where they prepared food for the soldiers.

The typhoid bacillus was discovered eighteen years before the Spanish-American War, the Widal reaction had been in use for three years, the mode of infection and methods of prevention had long been known. Yet in an army of 107,973 men, there were 20,738 cases of typhoid fever.

The Boer War was an even greater blot on the pages of the history of sanitation. The British had apparently profited little by the American experience. In this war, the British Army lost 22,000 men, of whom 8,000 had been killed in battle or died of wounds, while 14,000 died of preventable diseases. There were 57,684 cases of typhoid fever with 8,022 deaths. The typhoid bacillus had killed more men than the Boers.

The high typhoid fever rate in the British Army during the Boer War seems inexcusable in the light of present knowledge. Three years before the Boer War, Wright had demonstrated the protective value of antityphoid vaccines, and two years later had inoculated four thousand men of the British Indian Army, with excellent results. The British Army in South Africa authorized — permitted is perhaps a better word — voluntary vaccination. The vaccination was carried out in a rather haphazard fashion, records were poorly kept and often lost. The army authorities finally forbade the inoculations altogether.

Two years after the close of the Boer War a Royal Commission appointed to study the value of Antityphoid vaccination issued a favorable report which rehabilitated the procedure of antityphoid inoculation. It came too late, however, to aid the typhoid victims of the Boer War, but

it carried a poignant message to the armies in future wars.

With the turn of the century there came a turn in the health record of armies engaged in war. During their war with China in 1894 and 1895, the Japanese lost four times as many soldiers from disease as from bullets. Indeed, this had been the record of armies for decades. These figures appalled the Japanese government, which reorganized its military medical service and sent thousands of young Japanese all over the world to study the latest advances in sanitation. Japan, to quote Major Seaman, writing in 1905, "even had the temerity (strange as it may seem to an English or American Army official) to grade her medical men as high as officers of the line, who combat the enemy that kills only 20 per cent."

The report of the Japanese Army at the end of the Russo-Japanese War showed the wisdom of their policy. Seven per cent died in battle; 1.5 per cent died of disease.

The first World War proved that the United States Army had profited by its own mistakes in the Spanish-American War and by the mistakes of the British in the Boer War. The lessons of the Russo-Japanese War had also been studied and learned.

Typhoid fever, the great scourge of past wars, claimed only 213 victims in the American Army of 4,000,000. If the typhoid death rate of the Spanish-American War had prevailed, more than 68,000 soldiers would have lost their lives from this disease. Surgeon General Ireland of the United States rightly attributed this decline to vaccination and improved sanitation, including careful examination of cooks and food handlers.

Tetanus caused only four deaths in the American Army, less than two out of every hundred thousand wounded. This figure is especially noteworthy, since the British in the early years of the war had thirty-two cases in every thousand wounded. Prophylactic injections of tetanus antitoxin in all the wounded explained the astonishing American figures.

Typhus fever did not cause a single death in the American Army. The figures from Russia were quite different and, indeed, appalling. During the war and the succeeding revolution, sanitation broke down completely in Russia. There were more than twenty million cases of typhus in Russia, with three million deaths.

The medical experiences of the First World War demonstrated the great advances made in the prevention, control, and cure of certain infectious diseases. Two great groups of diseases, however, remained untamed. "The sputum-borne infections," observed Colonel Garrison, "particularly the pneumonias, remained the insoluble problem of the war." To this must be added streptococcic infections, which caused seventy per cent of the fatal infections in the British Army. And they remained for ten or more years an insoluble problem.

While we think of disease and war, we are prone to think only of infectious diseases and gloss over or neglect the role that disease due to faulty or insufficient nutrition plays. Prominent among these diseases is scurvy.

Scurvy appeared in the armies of the First Crusade. Jacques de Vitry, one of the crusaders, wrote an excellent account of this disease as it appeared at the siege of Damietta in 1219, and notes that it was a "pestilence, against which the doctors could not find any remedy in their art." Later in the Seventh Crusade of 1248, the army of Louis IX of France was attacked by this disease, and no one, reading the account of Sieur de Joinville, can doubt that scurvy was largely responsible for the disaster that befell Louis' army.

In 1535 Jacques Cartier's expedition to Canada suffered greatly from scurvy and probably would have perished to the man, except for the aid of the Indians, who told him that a decoction of the bark and leaves of the fir tree would cure the disease. Cartier's physicians had been powerless in the extremity, so we can understand his oft-quoted remark that the decoction of fir "wrought so well, that if all the physicians of Montpellier and Louvain had been there with all the drugs of Alexandria, they would not have done so much in one year as that tree did in six days."

The work of James Lind, who found that lime juice added to sailors' rations would prevent scurvy, is one of the great discoveries in medicine. Yet, incredible as it seems today, Lind waited forty-two years before he saw his measure put into effect by the British admiralty. The French seemed even more blind than the

British to the importance of Lind's discovery. Larrey relates that Napoleon's army in Egypt was decimated by scurvy in 1799, incidentally forty-six years after Lind's discovery. The addition of lime juice to the rations of the French soldiers in Egypt might have proved a decisive factor in the campaign.

Since the demonstration that citrus fruits, added to rations, prevents scurvy, this disease has lost its military importance. In the recent Italo-Ethiopian War, there was not a single case of scurvy in the Italian Army, although the Ethiopian Red Cross reported over thirty thousand cases of scurvy in their army on the Somaliland front alone.

The medical history of the American Army in World War II has not yet been compiled, but if things go well, we have been promised this history in 1951. However, we have already scattered reports which allow us to form a fairly good impression of the performance of the Medical Corps during this greatest of all wars.

Typhoid fever, which was so deadly in the American Civil War and in the Spanish-American War, is not now a menace to our troops, thanks to vaccination and proper sanitation. Typhus fever was a rarity and most of the cases were seen among the civilian population. The prompt eradication of the dangerous typhus epidemic met in Naples by the medical corps of our army is a dramatic episode in the history of the medical corps, an achievement which would have been impossible in the past. Typhus fever, which had not appeared in Naples for fifteen years, was imported into Italy in 1943 by refugees from the Balkans. The entire population was deloused mainly with DDT, a large number of the inhabitants were vaccinated with typhus vaccine, and the disease promptly disappeared. What a contrast to Napoleon's experiences in Russia!

Malaria continued to be a grave problem, particularly in the South Pacific. Yet it was never the enemy it had been, for example, during the Spanish-American War. In the Cuban campaign, according to Colonel Theodore Roosevelt, every officer in his regiment, except himself, was down at one time or another with malarial fever. He wrote, "Though the percentage never got above twenty, there were less than fifty per cent who were fit for any kind of work."

The sputum-borne diseases, especially the pneumonias which Garrison called "the insoluble problem" of World War I, were no insoluble problem this time, thanks to the sulfonamides and penicillin. There were no frightful epidemics of pneumococcus or streptococcus pneumonias such as we saw in the last war. Even epidemic meningitis, which was so fatal before, no longer carried a death sentence to nearly half of the soldiers attacked. I know of one hospital unit which treated nearly three hundred cases without a death — thanks to sulfadiazine.

Just a few comparisions may highlight the medical advances in World War II as compared to World War I. The figures are those of General Hugh Morgan:

| | *World War I* | *World War II* |
|---|---|---|
| Death rate in wounded | 8.1% | 3.3% |
| Meningitis mortality | 38.0% | 4% |
| Pneumonia mortality | 38.0% | 0.7% |
| Dysentery mortality | 1.6% | 0.05% |
| Annual death rate per 1000 for all diseases in the Army, excluding surgical conditions | 15.6% | 0.6% |

In 1940 the Medical Corps of the United States Army consisted of 1,600 officers. On V-E day there were 47,000 doctors in the Army. Nearly three out of every four doctors were civilians in uniform, men who had studied medicine in competition with their fellow students, men who practiced medicine in competition with their colleagues, men who in great numbers had risen to eminence because of their industry and their ability and not because of a nod from some medical Fuehrer or Duce in Washington.

General Kirk, in a recent article, remarks, "I know that civilian physicians do not take kindly to the regimentation of the Army." That may explain the ill-concealed hostility with which they regard certain maneuvers in Washington. Possibly some of those in the seats of the mighty imagined that the doctors after four years of army regimentation had grown to like it and would prefer it to the competition of private civilian practice. Well, ask them.

A group hovering about the thrones of the mighty seem filled with the urge for sociological experimentation. They wish to employ us for what our off-and-on friends, the Soviets, call

euphemistically "social engineering". Possibly an anecdote related by Eugene Lyons describes the situation:

"Once," he writes, "I was with a group of Americans who stopped to talk to a Russian woman outside a bakery; one of those things that would enable them to write, 'I talked personally with ordinary Russians and despite the barrier of language I sensed their devotion to the Five Year Plan.' It fell to me to interpret. The woman answered our questions evasively, trying to say the 'proper' thing and embarrassed by the attention. As she talked she fingered the stuff of an American dress and studied the women's hats and shoes. Then, timidly, she inquired about the cost of various items of our clothing and whether they were difficult to get. Finally she said in a deprecating voice in which there was an undertone of cautious irony: 'Ask them how they like our life here.' I translated the consensus of group opinion: 'They think your life is very difficult just now, but most interesting!' 'Interesting!' The woman made a wry face; the word cracked her discretion. 'Interesting! Sure, it's interesting to watch a house on fire. But we're in it! Tell them that, citizen!' And she turned away angrily."

* * * *

War, with its horrors, has, according to some, its compensations in the great medical discoveries to which it gives birth. It is worthwhile to pause a moment and see if the history of medicine bears out this opinion.

Bubonic plague, which was spread far and wide by war, was conquered not in wartime but by the demonstration that rats carried the disease and by Kitasatos' discovery of the plague bacillus. Typhoid fever has been conquered by the proper control of water supplies and by antityphoid vaccination — both peacetime discoveries. Typhus fever has been controlled since Nicolle, working in the quiet and peace of his laboratory in Tunis, demonstrated that typhus was spread by lice.

Smallpox, which the Romans spread in their wars into Central Europe, was finally checked 1800 years later by Edward Jenner, a country doctor in Berkeley. Malaria, unchecked for centuries, was finally halted by quinine, brought to Europe by Jesuit priests. Anesthesia, so important on the battlefield, was discovered by another country doctor, Crawford Long in Georgia, while the principles of aseptic surgery were introduced by Joseph Lister, working in a small hospital in Glasgow. The X-Ray, so necessary to both the military and the civilian surgeon, was discovered in Roentgen's little laboratory in Wurzburg. Sulfanilamide and penicillin were both peacetime discoveries; indeed the great value of the sulfonamides might have been recognized twenty years earlier if the initial work done in 1914 had not been interrupted by the First World War.

Medical advances are certainly made in wartime. War is a vast laboratory of human suffering which gives an unparalled opportunity to test out the means of alleviating suffering. But the greatest medical discoveries were not made on the battlefield. The object of warfare is to destroy the enemy, not to advance medical science. War draws upon the medical wisdom of the centuries and although it often destroys the accumulated treasure and culture of the centuries, it does not destroy this wisdom, for that is indestructible.

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## VITALLIUM PLATES USED IN REPAIR OF LARGE HERNIAS

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Difficulty is commonly encountered in reconstructing the inguinal region when it is the site of a large direct hernia. The defects which are present in the abdominal wall are often large and the tissues about the hernial opening are stretched and atrophied. The transversalis or endoabdominal fascia is the one most defective and it is also the tissue most difficult to reconstruct because of its thinness and limited elasticity. The importance of this layer in restraining the peritoneal bulge in the inguinal region cannot be overemphasized. It bears the same relationship to the abdominal wall that the fabric does to the automobile tire.

Where the size of the opening in the fascia is so large that it cannot be brought together with-

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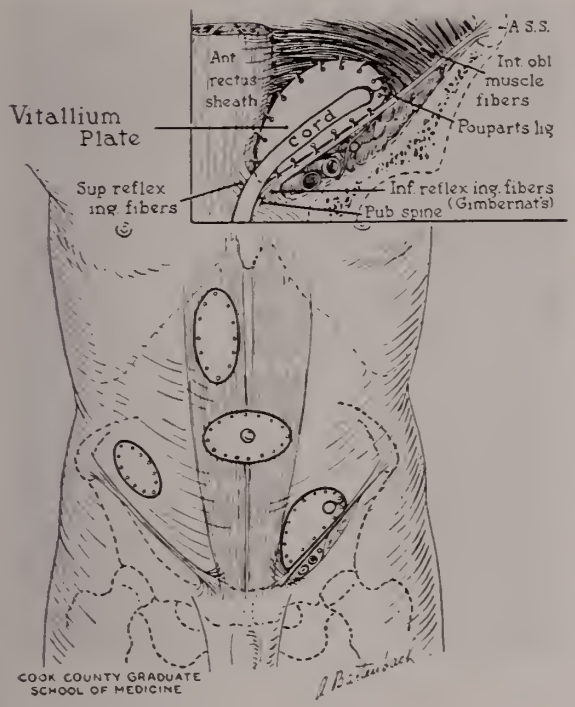



Figure 1. Plates of different shapes designed to meet hernial requirements in different areas.

*Insert I.* Shows inguinal plate in place with structures surrounding plate.

out undue tension or tearing, many surgeons have been prompted to bridge the defect with autogenous fascial grafts. Some measure of success has followed the use of these grafts, but they frequently fall short of their objective. These autogenous fascial grafts have no greater growth potentiality than the tissue into which they are to be implanted. *Thus, one is frequently taking old fascia from an old thigh and putting it in an old hole in an old man.* The mere transposition does not add any rejuvination to either the graft or the host.

It is with this thought in mind that we have employed in certain instances the implantation of a mechanical inert prosthesis to replace the defective parietes and act as a scaffold about which new tissue may grow. We were fully aware of the fact that surgeons in the past have employed various plates and filigres of metal and other substances to replace or strengthen defective parts of the body. The use of these mechanical supports have had to be, in many



Figure 2. Photograph of plate showing relative size and giving disposition of openings.

instances, discarded because of their irritation to the tissues in which they had been implanted.

In the past ten years much has been written regarding the inertness of Vitallium* and its tolerance by the tissues of the body. It was this passive or inert property that led the writers to make use of the alloy in anterior abdominal wall reconstructions. The metal plate which we have designed is fashioned to accurately fit the defective inguinal region. It is made of Vitallium which is an alloy offering practically no irritation to the tissues into which it is placed.† See Figures 1 and 2.

The plate is so constructed that the spermatic cord passes through an opening which offers pro-

*Vitallium is the trade-name given to an alloy whose approximate composition is Cobalt 65%, Chromium 30% and Molybdenum 5%. The authors thank Mr. Walter Klann of the Austenal Laboratories, Inc. for helping them develop the prosthesis which they are now using.

†Vitallium was originally developed by the Austenal Labortories as a dental alloy which was resistant to the corrosive action of saliva. In 1935, Venable and Stuck carried out some animal experiments on electrolysis of metals in the body. After demonstrating that Vitallium was inert or passive in body fluids, they operated their first patient in September of 1936. In the last ten years, Vitallium has not only established itself as a valuable alloy in bone surgery, but it has also found newer uses in other fields of surgery.

Pearce in 1940, and Clute in 1941, independently devised Vitallium tubes to be placed in bile ducts for repair of strictures or to replace irreparable damage.

Kimball and Drummond in 1941 successfully employed a Vitallium prosthesis instead of cartilage in nasal skeletal support in four cases. They encountered no untoward reactions, no infections, and no drainage.

In 1942 and 1943, Blakemore, Lord and Stefko made very interesting studies on non-suture methods for blood vessel anastomosis. They concluded that Vitallium is a non-irritating alloy suitable as a prosthesis for a vein graft bridging an artery or vein defect in non-suture method of vessel anastomesis using a single or double tube technic.



Figure 3. X-ray showing Vitallium plate in place.



Figure 4. Lateral view of pelvis showing plate above symphysis pubis.

tection to the region of the internal ring. The plate is also provided with perforations through which sutures can be inserted to hold it securely in place. Its position is such that it does not interfere with flexion of the thigh on the abdomen or with torsion of the pelvis. This *plate is designed for those hernias that do not offer themselves to the usual methods of repair.* See Figures 3 and 4.

In some umbilical hernias there is difficulty in finding sufficient tissue to bridge the defect. In such instances, it is possible to adapt a specially constructed Vitallium plate to the defective area. It should be placed deep to the rectus muscles, between them and their posterior rectus sheaths. It should be fixed to the posterior sheath with non-absorbable suture material. Plates have been designed also for other types of ventral and post-operative hernias where loss of tissue makes reconstruction difficult or impossible. See Figure 1.

*Technic*:

1. Inguinal incision.
2. External oblique aponeurosis was split in the direction of its fibers from the external ring to the level of the internal ring.
3. The cord was elevated and found to include a large indirect hernia of the sliding type. There was a portion of the sigmoid colon in the sac and it made up part of the wall of the sac. Medial to the deep epigastric artery, a broad-necked direct hernia presented itself. It too, was of the sliding type and the bladder made up part of the anteroinferior wall of the direct sac. These two hernias, direct and indirect, made an unusual combination of the so-called "pantaloon hernia" with the deep epigastric artery and the veins marking the crotch. The indirect hernia had sigmoid slide into its wall, and the direct hernia had bladder drawn into its wall.
4. The direct sac, medial and inferior to the deep epigastric artery was entered; it was of moderate size and very thick walled, obviously due to properitoneal fat from the lateral edge of the bladder.
5. The deep epigastric vessels were doubly clamped, ligated, and cut. This step converted the openings of the two distinct hernias into one common orifice. The bladder wall was recognized and pushed back into place.

6. One common opening for both hernias made it possible to replace both intra-abdominal organs by two purse-string invagination sutures.
7. A double catgut purse-string suture (No. 0) was carefully inserted in the peritoneum from the inside of the common sac just beyond the natural peritoneal reflections of the intra-abdominal organs, and then tensed and tied; this inverted all the contents into the abdomen.
8. A second purse-string suture was placed in the endo-abdominal fascia and further invagination accomplished.
9. The arched fibers of the transversus and internal oblique muscles were sewn down to the shelving portion of Poupart's ligament; endo-abdominal fascia was systematically included in these stitches.
10. The Vitallium plate was now placed over the newly repaired defect and the cord brought through the opening provided in the plate. The prosthesis lies in relation to the rectus sheath medially; the shelving edge of Poupart's ligament inferiorly; and the arched fibers of the inner two flat muscles of the abdomen superiorly. See Figures 1, 2, 3, and 4.
11. The plate was anchored to the above named structures by interrupted wire sutures, (No. 32). Sewing was facilitated by running the needle through the tissue first and then through the openings provided in the Vitallium prosthesis.
12. The external oblique aponeurosis which was split at the beginning of the operation was restored by suturing the two flaps together over the Vitallium plate and cord. The plate is thus sutured around its entire circumference; its posterior surface rests on the internal oblique muscle while the anterior surface lies immediately behind the aponeurosis of the external oblique.

SUMMARY

Certain large hernias of long standing are difficult or impossible to repair by the usual reconstructive suture methods. Autogenous fascial transplants have certain disadvantages. The use of a non-irritating 'argonic' prosthesis will materially aid in the ease and security of the repair of certain types of hernias. It will be found particularly useful in elderly people who are not compelled to do heavy labor.

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## RECENT DEVELOPMENTS IN THE TREATMENT OF HYPERTENSION

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The treatment of essential hypertension has been one of the unsatisfactory chapters in therapeutics. In many instances, no method at our disposal will serve to lower the blood pressure for any significant length of time. In other cases, the arterial tension can be lowered at least a considerable period. The question of the wisdom of attempting to reduce blood pressure in hypertension is often discussed. I feel that when we are able to do so it is the best thing to do. In such cases many of the disagreeable symptoms accompanying hypertension are frequently relieved and probably in some patients impending vascular accidents might be deferred or even averted.

There have been recent developments in the treatment of hypertension which indicate that we are making progress. Many of these developments are based on a sounder physiological knowledge of the cause of this condition. Until we are able to establish the cause of any clinical entity we are handicapped in finding a sound therapeutic basis for the lesion.

In any case of hypertension it is very important to determine whether or not we are dealing with essential hypertension or one of the less frequent causes of high blood pressure. Among less frequent causes occasionally encountered are acute and chronic nephritis, enlarged congenital polcystic kidneys which are revealed by abdominal palpation or x-ray, and tumors of the adrenal gland causing acute paroxysms of marked hypertension. Coarctation of the aorta will cause hypertension of the upper extremities and this lesion must be thought of in any young individual having a hypertension. In these patients, the abdominal aorta pulsation is difficult to find and the blood pressure in the legs is lower than that in the upper extremities. The x-ray of the chest in

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these patients will show the typical scalloping of the ribs. Unilateral or bilateral pyelonephritis occasionally causes hypertension. Basophilic adenomas of the pituitary are rare causes. Toxemia of pregnancy and urinary obstruction due to an enlarged prostate or renal calculus may be accompanied by hypertension.

The general care of the patient is important. An effort should be made to get them to take things more easily and face unpleasantness with equanimity. Excessive concentration on business should be stopped and the patient induced to devote a sufficient portion of his time to play and amusement. Regular hours should be kept, sufficient rest secured, and the perpetual hurry of our present life avoided as far as possible.

Faulty health habits when present should be corrected. These include habitual over-fatigue, excessive caloric intake, excessive worry, and stress. Exercise within reasonable limits is not only permissable but should be encouraged. One must be careful not to give his patient the impression he is an invalid because many hypertensives develop a neurasthenic disposition.

No dietary treatment is known which has a specifically favorable effect on essential hypertension. We certainly should not tell our hypertensive patients that they must not eat meat, eggs, dairy products or salt, a practice frequently resorted to in the past. However, the obese hypertensive patient should be reduced to a more satisfactory weight level. In such cases we frequently see some fall in pressure after a moderate reduction in weight from an obese level. Recently, the "rice diet" has been advocated by Kempner[1]. I have had no experience with this diet but doubt that the average hypertensive would follow it very long.

There is no evidence that alcohol plays any part in the causation or aggravation of essential hypertension. In fact many patients with vascular disease are now being encouraged to take a small amount of alcohol daily. Naturally, no hypertensive patient should be allowed an excessive consumption of alcoholic beverages.

Recent evidence demonstrates that tobacco will increase the blood pressure of the hypertensive patient. In a well controlled investigation Hines and Roth[2] demonstrated an immediate rise following cigaret smoking in either systolic or diastolic blood pressure or both in most of the hypertensive subjects tested and the main rise was of considerable amplitude. The main rise in blood pressure was less in the control group of non-hypertensives and in some instances there was even a fall in diastolic pressure. Excessive rises in blood pressure from smoking occurred only in the patients who had evidence of an inherently hyperactive vascular system.

The medical treatment of essential hypertension has often been disappointing. Kapernick[3] found no particular value for the reduction of blood pressure in hypertension in the use of such drugs as theobromine, theobromine and phenobarbital sodium, iocapral, theophylline ethylenediamine, erythrol tetranitrate, hepvisc, and allimin. According to his observations no depression of blood pressure can be expected from their use. Phenobarbital combined with some of the above frequently allays nervousness with some lowering of pressure. It is common knowledge that pressure is frequently lowered through suggestion alone. This was well demonstrated many years ago when Ayman[4] enthusiastically prescribed nothing but dilute hydrochloric acid to hypertensive patients and found some lowering of pressure in a large percentage.

Recently, vitamin A concentrates have been used in an attempt to lower pressure. Taylor and his associates[5] studied the effect of vitamin A concentrates given in amounts of 100,000 to 400,000 U.S.P. units daily for from five to ninety days. No alteration of blood pressure levels was noted in any of the cases studied. In contrast to this report is one of Govea[6] who stated that almost fifty percent of 420 patients with hypertension treated with massive doses of vitamin A showed a significant reduction of blood pressure. He reported an improvement in subjective symptoms. Pond and Rosen[7] also report success in the use of vitamin A. Katz, Rodbard and Meyer[8] studied the effect of vitamins A and D on dogs with experimental hypertension. They were unable to show that vitamin A in large doses was capable of lowering the blood pressure in these animals. Vitamin D failed to elevate the blood pressure in normal dogs. Only occasionally were slight variations noted when these substances were administered in doses sufficiently large to be effective.

Among other drugs or products recently advocated is testosterone, the male sex hormone.

Marquez[9] reports definite improvement in the subjective symptoms as well as reduction of the arterial pressure. This work has not been confirmed by others.

Recent work has lead to the theory that hypertension may be due to some humoral mechanism of renal origin. Goldblatt[10] demonstrated that if the blood flow through the kidneys of dogs is significantly reduced by partial clamping of renal arteries persistent hypertension invariably resulted. Page[11] was able to produce chronic renal hypertension due to a constricting perinephritis which resulted from wrapping cellophane or silk about the kidneys. As a result of this work, the hope of successful therapy by renal extracts appeared. The possibility of developing this therapeutic method for reducing high blood pressure rests upon the basis that in the kidneys of animal and man, a substance called renin is produced. This substance combining in the blood stream with a chemical designated as an activator produces a third substance which has pressor action and has been named angiotonin. The kidney also produces a substance which apparently counteracts angiotonin lowering blood pressure in hypertensive animals. When a kidney becomes diseased, however, a secretion of renin is believed to overbalance its secretion of this inhibitor of hypertension. As a consequence, the excess of renin leads to the production of an excessive amount of angiotonin which subsequently raises the pressure. This observation led to the preparation of kidney extracts which appear to produce their anti-pressor action at least partly through their ability to neutralize angiotonin. Page[11] reported the use of kidney extracts in a series of thirty-seven patients, twenty-four of whom had malignant hypertension and thirteen essential hypertension. Nine of the group of malignant hypertension died, six in uremia, and three of cerebral hemorrhage, whereas, none of the cases of essential hypertension resulted in a fatality. The most striking changes following treatment were reversal of eye ground abnormalities with improvement in vision, increase in cardiac output, and decrease in diastolic blood pressure. Unfortunately, because of occasional shock-like reactions, the lack of standard chemical procedures to yield a uniform product of high potency and the great difficulty of their preparation, renal extracts cannot at present be regarded as a practical means of therapy. In a recent personal communication Page stated "Work on the kidney extracts has been discontinued temporarily. At the stage it was left, certain things had become clearer. The first of these is that the kidney contains a protein which depresses arterial blood pressure in dogs and rats with experimental renal hypertension. This is now established beyond any doubt. There is a tendency, however, on repeated injections of this protein, for the animals to become refractory to it. This problem will be investigated in the future. The work on patients has, I think, shown that some patients respond quite well with a fallen blood pressure, but it is uncertain how much of this fall is due to the depressor protein and how much is due, for want of a better term, to nonspecific reaction. It seems fair to say that the use of kidney extracts has distinct possibilities in the treatment of patients with hypertension, but the work should not be considered any more than a clinical experiment. There is little reason to suppose that when work is resumed on them that any immediate practical solution of the problem will be achieved."

At present, the drugs having the greatest effect in lowering the blood pressure in essential hypertension are the thiocyanates. The use of thiocyanates in the treatment of hypertension has be- of a practical method for determining the blood come more popular since Barker's[12] introduction thiocyanate level and his demonstration that the drug may be used safely and effectively in controlled cases. The use of the drug had previously fallen into disrepute because of the frequency of severe toxic symptoms and even deaths accompanying its use.

Several years ago Allen and I[13] attempted to determine if the thiocyanates could be used safely and effectively in the treatment of hypertensive patients seen in private practice using laboratory facilities available in the average community. Previous to that time all of the reports had appeared from large clinics and teaching hospitals having unlimited laboratory facilities and where the expense to the patient was of no necessary consideration.

The initial group of patients reported included 19 unselected cases of hypertension with systolic blood pressures remaining above 200 mm. and diastolic pressures above 120mm. on the usual

forms of therapy such as theobromine, nitrates, sedatives, etc. All had been observed for a period varying from three months to three years before the thiocyanates were administered. We believed such a control period removed the factor of suggestion from the evaluation of results. A much larger number of other patients have been studied since the initial report and the results are comparable with those previously reported and summarized below.

During the early months of the investigation no attempt was made to select cases other than that they had been observed over a sufficient control period and that their systolic and diastolic pressures were not below the minimum indicated above. As a result we included five patients with severe renal damage as shown by marked albuminuria, elevation of non-protein nitrogen, and decreased phenolsulphonephthalein excretion. At present such individuals are not given thiocyanate because of the unsatisfactory results obtained in this type of patient.

During the course of treatment all patients are seen at regular intervals and the blood thiocyanate determined. The technical assistance of Miss Mary Mintert, M. T. (ASCP) in determining the blood thiocyanate levels is gratefully acknowledged. Blood pressure is taken under similar conditions such as time of day and relation to meals. They are carefully questioned for any symptoms suggesting toxic reactions. At the onset of treatment, the frequency of observation is every two weeks but the interval is increased to four weeks after the thiocyanate level becomes stabilized. The patient is given a prescription containing six grams of potassium sulfocyanate in 240 cc. of 25 percent aromatic elixir and instructed to take one teaspoonful three times daily, or given tablets of 0.18 grams, two daily. In order to obtain a satisfactory blood thiocyanate level it is frequently necessary to increase the dose. The dose of the potassium thiocyanate is varied according to the thiocyanate level which we attempt to maintain between seven and 10 milligrams percent. After this level is attained the maintenance dose is usually less but varies considerably in individual patients.

We consider the result excellent when the systolic pressure falls to 170 mm. or below with a corresponding fall in diastolic pressure and the patient feels symptomatically improved. The result is considered good when the blood pressure decreases but not as great as indicated above and if symptomatic improvement also occurs. Results are considered poor if no fall in blood pressure occurs, if there is no symptomatic improvement, or if toxic effects force discontinuing the treatment.

In the original group studied, the results were excellent in 10 cases, good in two and poor in seven. The average fall in blood pressure in the improved cases was 46 mm. systolic and 22 mm. diastolic. Five of the cases which are considered among the poor results are those having severe renal damage. Although three of this group showed a significant fall in blood pressure, the patients were not symptomatically improved and the course of their disease was not altered. In those with no demonstrable renal damage the results were poor in only two. In both of these there was a satisfactory fall in pressure but the drug had to be discontinued because of generalized skin eruption which recurred when an attempt was made to resume treatment. Later studies demonstrated that one of these two patients had a functionless right kidney due to an atrophic pyelonephritis but the function of the left kidney was normal. A nephrectomy was performed. In spite of lack of symptomatic and clinical improvement this patient lived until a few weeks ago when he died suddenly. The other patient had an excellent response in blood pressure and felt symptomatically improved until the severe skin eruption forced discontinuing treatment. This patient also had frequent attacks of angina pectoris preceding treatment with potassium thiocyanate. The frequency of the anginal attacks was not changed during the course of potassium thiocyanate and have persisted since treatment was discontinued. There was a return to the previous high level of her blood pressure after the conclusion of thiocyanate therapy. This patient is alive and fairly active indicating the relative benign course often seen in essential hypertension. The degree of hypertension persists. The results in our more recent cases indicate a satisfactory fall in pressure with symptomatic improvement in more than 50 percent.

Symptomatic improvement usually accompanies a fall in blood pressure. This includes a decrease in severity and frequency of headaches, less nervousness and irritableness, less insomnia,

and less vertigo. One might question the improvement in headache as due to the fall in blood pressure since thiocyanate apparently improves some cases of migraine without hypertension.

We have encountered no serious toxic effects except in the two cases with severe dermatitis and this disappeared after discontinuing potassium thiocyanate. Soon after the onset of treatment some complain of increased lassitude and weakness but this usually disappears within several weeks. More marked fatigue and weakness accompanied extremely high blood thiocyanate levels (20 and 24.4 mgms. percent) in two patients but were not present at satisfactory blood levels. Other minor toxic symptoms reported consist principally of aching in the legs, slight epigastric distress, nausea, and decreased libido. Rarely, marked nervousness may be manifested. More serious complications mentioned in the literature include angina pectoris, exfoliative dermatitis, congestive heart failure, cerebral thrombosis, psychosis, acute goitre and thrombophlebitis. Usually these can be avoided or anticipated by close scrutiny and control of the patient on his frequent visits. The acute goitre when developing is often large, makes its appearance suddenly and may be painful usually because of a rapid increase in size. The pathologic picture is not that of exophthalmic goitre and there are no clinical evidences of thyrotoxicosis. The description of thiocyanate induced goitre by Rawson, Hertz, and Means[14] includes enlargement of the thyroid gland, symptoms of hypothyroidism with low basal metabolism, often exophthalmos and decreased excretion of the thyrotrophic hormone in the urine in the inactivated form. Apparently, the appearance of this type of goitre can be prevented by the assurance that the patient has had previously an adequate amount of iodine and after the goitre has developed it can be controlled by the proper administration of thyroid. None of our patients developed goitre. Koffler and Freireich[15] have reported four cases of thrombophlebitis in patients treated with potassium thiocyanate. We believe that potassium thiocyanate may be used safely and effectively in private practice in selected cases of hypertension providing the blood thiocyanate level is controlled. This determination is not difficult or expensive to perform.

However, the use of thiocyanate is not without danger and is not the perfect form of treatment for hypertension. However, no other drug has produced comparable results. The drug should be discontinued after no improvement has occurred with a satisfactory blood thiocyanate level. A response to thiocyanate therapy might be expected in an individual under sixty years of age with severe hypertension or with symptoms due to high blood pressure and without demonstrable renal or cardiac insufficiency. It is true that an occasional patient might be encountered who is sensitive to the drug but this is true of many valuable drugs including arsphenamines, sulfonamides, etc.

Approximately, 3,000 cases of sympathectomy have been performed since 1925 as a therapeutic measure for hypertension. All of these surgical procedures have consisted largely in removing portions of the sympathetic nervous system particularly those having to do with the vasomotor control of the vascular supply of the viscera of the splanchnic bed. The purpose is to lower blood pressure by decreasing the tone of arteriolar smooth muscle. Results of several investigators suggest that in a significant percentage of patients with continued diastolic hypertension lowering of blood pressure for a considerable period has resulted from surgical intervention of this sort. This has been associated with favorable changes in the eye grounds, electrocardiograms, and cardiac and renal function as measured by ordinary tests as well as symptoms. The first operation seems to have been done by Roundtree and Adson[16] in 1925. They removed the second, third, and fourth lumbar ganglions without significant effect in a patient with malignant hypertension. Later Adson cut the sympathetic nerves by resection of the anterior route. This operation requiring laminectomy was apparently effective but was given up because of its difficulty and high mortality. In 1934 Craig and Brown[17] carried out unilateral and bilateral infradiaphragmatic splanchnicectomy in a few cases with resection of the first and second lumbar ganglions. In 1935, Peet[18] reported his initial studies of supradiphragmatic bilateral splanchnicectomy with lumbar gangliectomy adding in some cases partial

adrenalectomy. In 1940, Heinbecker[19] reported his studies on splanchnic section. Heinbecker also denervated the adrenals. Smithwick[20] describes a two-stage bilateral transdiaphragmatic operation by which he removes the entire great splanchnic nerves, their aortic branches, and the sympathectic ganglions, the tenth, eleventh, and twelfth dorsal ganglions, and the first lumbar in the minimal operation and excision of the sixth thoracic to the third lumbar in the maximal operation. Finally, Grimson[21] has reported a group of almost total bilateral sympathectomized cases. At Barnes Hospital, Heinbecker[22] has performed sympathectomy and denervation of the adrenals on more than 100 cases with an insignificant operative mortality. Three of these have been patients whom I have observed in private practice before and after surgery. One was a twenty-one year old white married woman who had a very moderate hypertension previous to her first pregnancy. Early in the pregnancy her pressure became very high indicating the effect of pregnancy on a very moderate pre-existing hypertension. Her pressure did not fall. It remained at levels of approximately 230 mm. systolic and 150 mm. diastolic. Bilateral sympathectomy with adrenal denervation was done by Heinbecker. There was very little change in her pressure although she remained comfortable and active for at least two years afterwards when she developed a massive cerebral hemorrhage and died within a few hours. She worked daily as a stenographer and the hemorrhage occured while working. Another patient was a 33 year old white woman who had incapacitating headaches. Her pressure was 230 mm. systolic and 130 mm. diastolic and there was blurring of the optic discs with some hemorrhages. The headaches have disappeared entirely following surgery. Her pressure fell considerably and the eyeground changes regressed but during recent months there has been some increase in her pressure although she is symptom free. The third patient was a young woman who had hypertension for approximately five to six years. Soon after sympathectomy and adrenal denervation her pressure fell to within normal limits. She was one of the infrequent patients who developed postural hypotension and tachycardia following sympathectomy. This was troublesome for several weeks but later disappeared. However, a year following the operation, the pressure increased some but has not reached its previous high level. Heinbecker contends that splanchnic section will not lower blood pressure appreciably once the renal ischemia is effected by mechanisms not under nervous control. He further states that symptomatic relief from nervous symptoms will be afforded in over seventy percent of cases. He considers this an effect of adrenal denervation. It is secured in many cases regardless of the effect on blood pressure.

Smithwick's[20] report included 156 patients followed one to five years. As indicated above Smithwick's operation is more extensive than most of the other operations. Smithwick believes that failure to modify the hypertension in a given patient could be due to inadequate surgical operation. He contends that failure to decrease the hypertension following a lesser operative procedure can be converted into a successful result by removing more extensive portions of the sympathetic trunks in subsequent stages. Smithwick's operative mortality was 2.8 percent. He divides his results into five groups, according to the magnitude of the effect on the horizontal resting diastolic blood pressure level. In Group 1 there was a lowering of 30 mm. or more; in Group 2, of 20 to 29 mm.; in Group 3, of 10 to 20 mm., and in Group 4, up to 10 mm.; in Group 5 the blood pressure was higher. The average reduction for the first four groups was 61/43, 44/24, 27/15, and 10/5 mm. respectively. In Group 5, the average elevation was 18/11 mm. The results for 61.5 percent of the patients fell into Groups 1 and 2, those for 79.4 percent, into Groups 1, 2, and 3, and those for 20.6 percent into Groups 4 and 5. The results of Groups 1 and 2 are regarded as significant and of Group 3 as probably significant. The 156 patients have been followed an average of twenty-two and one-half months. He concludes that a further period of observation is needed to determine the duration of the effect of operation.

We certainly must conclude that the surgical treatment of hypertension is most promising and further investigation is warranted. It is based on a sound scientific background with an attempt to remove etiological factors. It is still on an experimental basis and should remain in the hands of those surgeons who are thoroughly familiar with this type of surgery. Although progress

has been made toward determining the type of patient most likely to benefit from sympathectomy more rigid standards will probably be formulated in the future after further study of the accumulating mass of statistics. This should also determine which of the various surgical procedures is best adapted to the average patient having essential hypertension. Probably some of the procedures are not extensive enough while others are too radical and the disagreeable symptoms and results might outweigh the additional decrease gained in the blood pressure.

### CONCLUSION

We are facing a more promising future in the treatment of essential hypertension. Thiocyanates are helpful in selected and controlled cases. The concept that essential hypertension results from primary kidney disease has stimulated the use of renal extracts but they have not attained a practical clinical use at present. The results reported by the surgeons advocating sympathectomy are encouraging but many years of observation are necessary to determine the effect of this procedure in increasing life expectancy and delaying cardiac, renal and cerebral complications in patients having essential hypertension.

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## TREATMENT OF FRACTURES OF SUPERIOR AND INFERIOR MAXILLA

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Fractures of the superior and inferior maxillas are increasing in number. They are increasing also in the amount of dislocation and severity of the trauma to the bones and tissue. In 1915, Dunning[1], reported Stimson's work which showed mandibular fractures rated tenth in a list of percentages of fractured bones of the body. In 1928, Reiter[2], placed it sixth, at which place it has remained. During the past four years in my practice, fifty percent of these cases were the result of traffic involvements, forty-two percent were industrial accidents, and the remaining eight percent were received in recreational activities.

An injured person is entitled to the best results obtainable, and to secure these, the earliest possible consultation and treatment is urgent. I like Stevenson's[3] idea of studying and treating each fracture as it presents itself. In our local hospital, when a jaw injury is admitted, an oral surgeon is brought in to give his advice as to the aligning of the teeth and the securing of a func-

tioning bite. The general surgeon with a large fracture practice advises as to the alignment and general condition of the patient. An otolaryngologist is always called in because of his knowledge of the anatomy of the head and neck.

I have observed unsatisfactory end results in depressed fractures of the superior maxilla. Too many of these have been my own patients. These poor results were usually a drooping of the outer one-third of the infraorbital ridge. In none of my so-called poor results has any patient complained because of lagophthalmos or a drooping of the infraorbital ridge. However, in some instances, I know that better results could have been obtained. These unsatisfactory results were not due to failure to replace the fragments, but rather because these fragments were not adequately held in place. No attempt was made to immobilize the fragments beyond the gauze packing in the antrum, which proved insufficient.

Many devices have been recommended to obtain immobilization of the fragments of the superior maxilla and to keep the infraorbital ridge in place. Crawford and Blun[4], with suggestions from Erich, have an excellent head band for immobilization of fractures of the upper jaw that has advantages over plaster in that it is applied directly to the skull. I have been using a Straith's[5] head band with his nasal and alveolar attachment. I do not believe one can get enough stabilization from any head band unless it is attached directly to the skull or buried in a well placed plaster cap. This plaster for the Straith head band should be put on according to these directions supplied by the manufacturer:

"For a permanent fixation, using the head band, a plaster head cap can be made using stockinette over the head, a small amount of cotton wadding and plaster bandage, fitting well down behind the occiput over the ears and down to the eyebrows with a well fitted crown to prevent its downward displacement. The vortex need not be covered. After two or three rolls of plaster have been applied, the head band can be placed over the plaster, adjusted to size and another roll applied to hold the band in place, being sure to leave the binding posts, etc. exposed. If desirable, coat hanger wire side arms and the separate binding post over the nose can be incorporated in the plaster head band."

Unless the Straith head band is firmly anchored similarly to the above procedure, there will be a tilting and loosening, and a failure of the extension. The alveolar and nasal attachment may be attached to the many rods of the Straith head band. The nasal attachment is adjustable and supports the inside of the nose as well as controlling the shape of the outside of the nose. The alveolar plate is adjustable and dental low fusing impression compound may be used to apply pressure or ease it.

Parker[6] and Asbell[7] stress the importance of a good cosmetic effect, as well as the necessity of normal occlusion. Everyone agrees with them. Stout[8] states clearly the importance of the early treatment of shock and immobilization. A good cosmetic result is more possible if the fracture can be treated before the initial deformity is obscured by swelling.

At the Dixon Public Hospital a badly injured person is treated as follows:

1. The hemorrhage is controlled.
2. The patient is kept warm and quiet.
3. Plasma and whole blood are given as indicated.
4. Tetanus antitoxin, 1500 units, is always given. This may be combined with gas antitoxin.

With the hemorrhage controlled and shock treatment started, a careful inventory of the wound is made as follows:

*Inspection*: This is important if the patient is seen early. If the patient is seen late the swelling is so great that correct observation is obscured. The nasal tissues should be shrunk and inspected internally.

*Palpation*: Using the index and third finger of each hand the infraorbital and supraorbital rims, the forehead, zygoma, facial bones, nose, hard palate and the condyles and mandible are palpated. Thus, by palpation, elevations, depressions and separations are detected.

*X-ray*: Fractures involving the condyles may easily be missed by all other methods of examination.

*Treatment of the Patient*: If the patient's condition does not warrant immediate operation it does no harm to clean the wound with soap and water and then dry it with alcohol. The wound may be explored for foreign bodies and wound edges approximated with heavy silk as an emergency, so that the tissue does not have the opportunity to contract. When the patient comes for a final procedure these stitches are removed, the wound again cleansed and explored for foreign bodies. Meticulous care is used in approximating the wound edges. The deep

tissues are approximated with interrupted 000 to No. 2 chromic catgut. Then the skin closed with subcuticular and interrupted dermal. The outside stitches are removed in seventy-two hours and the subcuticular in seven days. The strain is taken from the wound with adhesive bandages.

For a simple depressed facture of the Superior Maxilla, a Caldwell-luc opening is made in the antrum and a window into the inferior meatus of the nose, and the depressed fragments are then elevated with urethral sound. These fragments are held in place with nu-gauze packed firmly in the antrum. If the infraorbital ridge is displaced, this is replaced and a Roger Anderson pin is placed in the fragment and this is held out for twelve days with an extension rod, held in place by a Straith splint. Much better results will be obtained in the simple depressed fracture of the antrum by nu-gauze packing than by placing a pin for extension in the cheek as the latter causes an unnecessary blemish. Pins and other methods of extension should not be placed in the middle of the cheek as this produces extra scarring which too, has to be removed. The zygomatic fractures are always reduced through the intraoral route. Even before the days of penicillin or sulfa, many zygomatic fractures were reduced by this route without infection. I have always made a large incision above the second molar and used a urethral dilator as an elevator to elevate the process. My finger was then inserted internally to determine whether or not my elevation was sufficient. If there had been a clean break, this was sufficient and then a rubber gutta percha was tightly packed under the process. This was sutured and held in place for four days. If the zygomatic process was shattered it was elevated intraorally and packed with rubber. Previous to the days of skeletal traction an incision was made and a hole drilled in the process and an ordinary screen door screw inserted. This was held out with a rod buried in a plaster cap. Now a Roger Anderson pin and a Straith splint are used.

If the hard palate and alveolar process are involved the oral surgeon and the otolaryngologist do an immediate repair, suturing the bony fragments of the hard palate together with cotton sutures. The remaining teeth may be wired together if thought advisable. By using the Straith mouth piece and some dental compound it is astounding how the oral surgeon will mold the hard palate and alveolar process into a perfect functioning process, both from an esthetic and functional standpoint. These badly splintered hard palates and alveolar process fractures will heal if only brought into alignment and immobilized. These cases require the daily attention of the oral surgeon, not only from the standpoint of cleanliness, but also in order that any errors in correction at the time of initial immobilization may be adjusted. These changes can be accomplished much more easily with dental compound than with dental wiring.

If the inferior mandible is fractured in one or more places these fractures are always immobilized first. The reason for such procedure is that the patients feel so much better when they can talk and when food can be utilized. All fractures of the mandible in which there is displacement or floating pieces are immobilized by external skeletal fixation. It was first thought that skeletal fixation should be reserved for edentulous patients or fractures of the angle. It has been found that the condyles can be pinned, aligned and immobilized safely and easily and that all types of fractures of the mandible can be successfully immobilized with perfect control of all fragments and anatomical reposition. There is the advantage of immediate movement of the temporo-mandibular joint and cleanliness of the whole buccal cavity.

One sees cases where the pins were placed too high. They were in the loose tissues of the alveolar process and at all angles. If excellent results are to be obtained the skeletal fixation must be applied correctly. Waldron[9] tells so well how to place the pins:

> "The pins are inserted through the skin without incision and through the mandible about 5mm. above the lower border. The pins are placed at an angle of approximately 70 degrees with the new tower chuck. The pin clamps are then applied and connected by a rod and thus a strong and secure fixation of the fragment is assured. A second unit is placed in the adjacent fragment. The displacement is then reduced manually and the fracture immobilized by joining the two units together by means of fixation rod. This appliance can be loosened and adjustments made in the event complete reduction was not obtained at first."

I am enthusiastic about this skeletal fixation. All of my pins have been well placed and healing

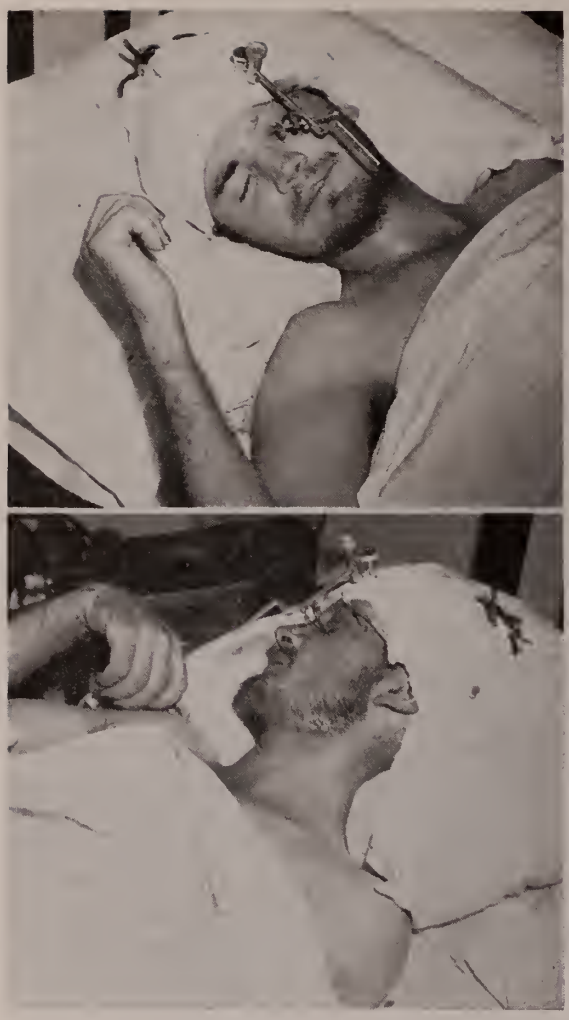


Figure 1 and 2 shows Roger Anderson pins placed in inner two-thirds of infraorbital ridge to keep elevation of free fragments.

and occlusion have been excellent. I recommend whole heartedly that before the first attempt at pinning condylar fragments, one go to the laboratory. One should place the pins in the attached condyle and then make a window and observe where the pins are placed. Through a skin flap, the condyle on the opposite side should be severed from the mandible with a Gibli saw at the point of fracture in the impending case. Then replacing the skin flap, the pins should be placed in this fragment. By having two pins in the fragment absolute fixation is established and the patient has all motions of his jaw.

All the following cases had their fracture reduced and their skeletal fixation or extension applied and wounds closed under Pentothal anesthesia. The operating time which included taking of x-rays for checking alignment, varied from forty minutes in the angle fractures to three hours and forty minutes in the more extensive injuries.

Case No. 1 (Figure 1 and 2). This case is a young man, age 23, who was severely injured in an automobile accident. Injuries included a crushing of the inner two-thirds of the left infraorbital ridge. Due to the marked swelling the deformity did not show in a photograph. Palpation demonstrated that the anterior surface of the left superior maxilla was crushed, with the infraorbital ridge pushed backwards and downwards well over one-fourth of an inch. Two Roger Anderson pins were placed in this ridge and the ridge held out in extension for fourteen days. The anterior surface of the left inferior maxilla was held out with gauze packing for seven days. The cosmetic and functional results were excellent.

Case No. 2 (Figure 3, 4 and 5) is a boy 18 years of age who came into a head on collision with four other boys while chasing a baseball. He was uninjured other than a depressed fracture of the anterior surface of the right superior maxilla and a marked drooping of the outer one-half of his right infraorbital ridge. A small incision was made over the ridge, a Roger Anderson pin inserted and this was held out for twelve days. The anterior surface of the maxilla was held out with nu-gauze pack which was placed in the right antrum through a Caldwell-luc opening. At the end of six days this packing was removed through an opening under the right inferior turbinate. His result is perfect, with no evidence of injury other than a white line on the right infraorbital ridge.

Case No. 3 (Figure 6, 7, and 8), man age 32, who was struck a downward crushing blow by a tire ring from an explosion of a truck tire. The lower two-third of his nose was completely severed from his face, but was connected by a small piece of flesh at the lower outer angle of his right ala. The anterior surface of his right superior maxilla was completely severed and the bony wall ground to pulp. His hard palate was broken into four pieces. An immediate repair was done under Pentothal anesthesia, shock was treated with heat and plasma. His blood was typed, a donor procured and the patient was given 2000 cc. of blood while he was on the operating table. The bony fragments were replaced and stitched where possible with cotton sutures inside his nose. These were allowed to slough out. The soft parts were brought together, the subcutaneous tissue were sutured with No. 1 chromic catgut, and skin closed with subcuticular stitch, and skin sutures of dermal. The hard palate and alveolar processes were stitched together and braced with low fusing dental compound and further supported by the mouth piece of the Straith splint. The nose was held in place by the internal and external attachment of the Straith splint. The patient's condition was critical





Figure 3 (top) shows depressed fracture of the outer one-half of his right infraorbital ridge with Straith head band buried in plaster cast. Note: Cast extends down and over occiput which keeps it from tipping.

Figure 4 shows patient two days later with antrum packed with nu-gauze and infraorbital ridge held in constant position by extension applied by rod from Straith head band and a pin in the infraorbital ridge.

Figure 5 shows the boy three weeks later with perfect results.

Figure 6 (top) shows absence of the lower two-thirds of his nose. The anterior surface of the right superior maxilla is absent.

Figure 7 shows two days later with nose replaced and held in place by nasal attachments inside and outside of the nose. The hard palate fragments are held in place by the mouth piece.

Figure 8 shows same patient eighteen days after the accident.



Figure 9 shows healed carcinoma in the symphysis of the inferior maxilla.

for four days. There was terrific swelling involving his scalp, face and neck. His nose and mouth could be kept clean and pressure applied and relieved as the case progressed due to the versatility of the nasal and dental attachments of the Straith splint. The hard palate remained intact bust most of the bone sloughed out, to be replaced with new bone over a two year period. In all this sloughing no true fistula developed. He was released from the hospital in twenty-two days, and at the present time has noticeable scars across his nose and right superior maxilla. There is a slight depression in his right superior maxilla and the nose is not absolutely straight. The tear duct on the right side had been severed and no attempt was made to create a new opening. This should have been done at the time of plastic repair. He does have, however, a very presentable appearance, and a perfect functioning nose and bite.

Case No. 4 (Figure 9) is a woman 69 years of age with a spontaneous fracture of the symphysis of her mandible due to a carcinoma. This fracture was held in place by Roger Anderson pins over a period of seven months. These pins had to be applied two different times as they loosened and came out. The necrotic part of the mandible was curetted and the carcinoma treated with x-ray therapy. After wearing the pins seven months and x-ray therapy the carcinoma disappeared and the whole area epithelized. There were no palpable glands in the neck. At the present time she has all motion of the jaw and eats solid foods. The only difference between this and previous management of similar cancer was the presence of this chrome nickel stainless steel and sulfanilamide. Such an excellent result stimulated Dr. D. L. Murphy to conduct a series of experiments with steel filings plus x-ray in the treatment of carcinoma throughout the body. His results have been interesting and will be published later.



Figures 10 and 11 show immobilization of fractures of the angle and the neck of the condyle with Roger Anderson pins.

Case No. 5 (Figure 10 and 11) is a man 35 years of age who was hit by a telephone post as it rolled off the truck. His inferior maxilla was broken in two places. The most severe factor was a break of the neck of the condyle and the right angle. These were immobilized with Roger Anderson pins and he was back to work in one month, with perfect occlusion.

## CONCLUSIONS

In the last three years twelve fractures of the inferior maxilla have been treated. All were immobilized with skeletal fixation. These fractures were as follows: three of the condyle, two of the symphysis, four of the angles, and three of the mental.

In all cases of the esthetic result has been excellent. In two of the badly shattered cases, where there were also fractures of the alveolar processes and hard palate, the alignment and bite have not been perfect but they are very functional.

Due to penicillin, sulfa, blood plasma and excellent first aid rendered by individuals trained by the Red Cross, many severely injured persons who formerly would have died now recover. All cases of depression of the infraorbital ridge should be given the benefit of extension. Skeletal fixation is the treatment of choice for all fractures of the inferior mandible where there is displacement. the injured patient should be given the best treatment first. This means the cooperation of the general surgeon with a dentist for alignment

and occlusion and with an otolaryngologist or plastic surgeon for treatment of injuries of the nose and the maxilla.

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## RECOVERY FROM PRIMARY FRIEDLANDER PNEUMONIA (Type B) On THERAPY WITH SULFADIAZINE AND PENICILLIN

NORMAN T. WELFORD, CAPT., M.C.

Bacillus Friedländer is the cause of from one-half to four percent of all pneumonias. The mortality rate of Friedländer pneumonia varies according to different authors from 71 to 97 percent, an average fatality rate of approximately 84 percent for all reported cases. Obviously the most important problem related to such a highly fatal disease is a therapeutic one. Since there is no known specific therapy for this disease, it seems appropriate to report a case of recovery which followed treatment with sulfadiazine and penicillin.

A 24-year old soldier, with two years' service in New Guinea, sustained a large perforation of the right ear drum following an explosion of an enemy bomb. One week later, on December 30, 1943, he began to have an aural discharge which persisted intermittently with progressive loss of hearing resulting in his being evacuated to the Zone of Interior. His family history was irrelevant. His past history revealed that since the age of two and one-half years, he had frequent upper respiratory infections associated with mild attacks of asthma.

On August 30, 1944, one week after his admission to Mayo General Hospital, he began to cough, complained of headache and had a temperature of $100^2$. On the second day, the cough became more severe and frequent following a chill. His fever rose to $103^4$. The cough came in paroxysms, was nonproductive, and was sufficiently severe to bring to mind the possible diagnosis of pertussis. On the following day, he complained of pain in the region of the sternum, the pain being markedly aggravated by coughing. His respirations were 24. Physical examination revealed wheezing asthmatic breathing and coarse ronchi, heard throughout both sides of the chest. There was impaired resonance over the right lower lobe.

X-ray of the chest on September 1, showed peribronchial infiltration and globular areas of increased density extending inferiorly into the right lower lung field. The x-ray diagnosis was "primary atypical type of pneumonia", (See figure 1). A culture of the sputum taken on the same day and reported two days later was strongly positive for baccillus Friedländer, Type B. The culture also contained some beta haemolytic streptococcus.

Treatment with sulfadiazine was begun September 3. This consisted of an initial dose of 4 grams followed by one gram every four hours with an equal amount of sodium bicarbonate. Due to the fact that the sputum was scanty, thick and mucoid in type, 1½ grams of ammonium chloride was given every four hours. On the following day, the cough was productive of large amounts of mucoid sputum containing considerable blood.

The patient's condition became rapidly and progressively worse so that on September 4, he was dyspnoeic, had profuse diaphoresis, and was quite cyanotic. Physical examination revealed crepitant and sub-crepitant râles with dullness and suppression of breathing over both lower lobes. The temperature was $102^8$, pulse rate 110 and respirations were 24. X-ray examination showed a spread in the pneumonic process involving both lower lobes, more marked on the right side. On September 7, our Roentgenologist made the following x-ray report: "There is further extension of the pneumonic process involving the

From Mayo General Hospital.

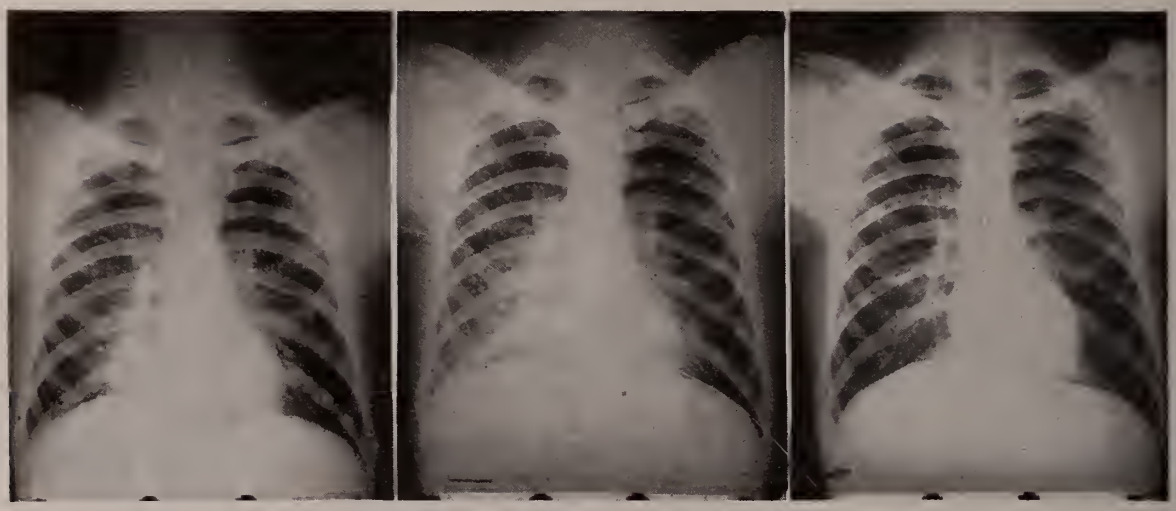


Figure 1 Figure 2 Figure 3

right lower lung field. There are additional patchy areas of increased density extending out to the lateral lung margin, and there is a definite tendency for the previously mentioned patchy areas to coalesce. The progress of the pulmonary involvement to date could well be described as typical of bacillus Friedländer pneumonia." (Figure 2)

At this time, his condition was critical. There was marked cyanosis which involved particularly the face and fingernails. He had spells of choking with a sensation of not being able to get his breath. In addition to extensive rales and dullness, he now had generalized wheezing. Sputum cultures still contained large numbers of Friedländer's bacilli after four days of sulfadiazine therapy.

On September 7, penicillin therapy was instituted by giving 25,000 units intramuscularly every three hours, a total daily dose of 200,000 units. Three days later, the dosage was decreased to 100,000 units daily for a period of four days. The temperature dropped to normal after eight intramuscular injections of penicillin. Beginning resolution of the consolidated areas in both lung fields was observed radiologically after 48 hours of penicillin therapy. There was marked clinical improvement, characterized by decreased expectoration, disappearance of cyanosis, and absence of dyspnoea. The patient began to show an interest in his surroundings and remarked that he felt very much better. Penicillin was discontinued on September 14, after a total of one million units had been administered. Gradual resolution of the pneumonic consolidation continued with complete clearing of the lung fields as evidenced by normal physical and x-ray examinations on September 28. (Figure 3) Sulfadiazine was decreased to four grams per day on September 13, and discontinued entirely on September 28.

Additional laboratory examinations performed during the acute stage revealed three negative blood cultures on specimens of blood drawn before chemotherapy was instituted. The white blood count varied between 5,700 and 11,700. The blood level of sulfadiazine during therapy averaged 9 mgm per 100 cc. Repeated sputum cultures were negative for tubercle bacilli. Susceptibility tests made in vitro indicated that this organism was non-susceptible to both sulfadiazine and penicillin. It was similarly noted in earlier observation made in this hospital that certain organisms, non-susceptible to penicillin in vitro, proved to be quite susceptible in vivo.

Despite the fact that the patient made a complete recovery from Friedländer pneumonia, he continued to have baccillus Friedländer in the sputum. Cultures of sputum taken five months after all evidence of abnormal pulmonary findings had disappeared, were still positive.

### COMMENT

Perlman and Bullowa reported a case of recovery from bacillus Friedländer pneumonia, Type B, following the combined use of sulfapyradine and Type II anti-pneumococcus serum[1].

The same authors in a review of thirty-seven cases of Friedländer pneumonia, eight of which were Type B, concluded that the administration of anti-pneumococcus serum, sulfanilamide, sulfapyridine or the combination of serum wth either of these two sulfa drugs seemed ineffectual in treating patients with this infection. Meyer and Amtman[2] reported a recovery in a case of bacillus Friedländer septicemia following the use of sulfapyradine.

Larsen[3] reported a case of recovery from severe bacillus Friedländer pneumonia after penicillin therapy was started on the eighth day of the disease. The drug was given intramuscularly in a dosage of 200,000 units per day. Recovery was reported as "dramatic."

In the case we have described, the infection spread rapidly during the first few days of illness. For four days, adequate sulfadiazine therapy was administered without effect. Recovery was dispaired of on the seventh day, at which time penicillin was started. Improvement was so decisive and spectacular within twenty-four hours, that penicillin seemed to play the role of a life saving therapeutic agent. This dramatic response attributed to the use of penicillin is somewhat surprising and quite contradictory to the commonly accepted fact that bacillus Friedländer is not a penicillin susceptible organism. The writer has no explanation to offer for this apparently parodoxical observation. The fact that at least one other case of Friedländer pneumonia "at the point of death" recovered when penicillin was the only therapy used, is significant[3]. It is also tenable that in our case, since sulfadiazine was continued in conjunction with penicillin therapy, there may have been synergistic action of these two chemotherapeutic agents. Such synergistic action of penicillin and sulfa drugs against certain penicillin resistant organisms has been demonstrated in vitro studies[4].

It would seem, therefore that the treatment of bacillus Friedländer pneumonia with penicillin either singly or combined with sulfadiazine is justifiable. Only when a sufficient number of such cases has been so treated and the result placed on record, can this method of therapy be fully evaluated.

SUMMARY

1. The clinical course and radiologic findings of a patient with bacillus Friedländer pneumonia are described.
2. Recovery took place following treatment with combined sulfadiazine and penicillin therapy after treatment with sulfadiazine alone proved non-effective.
3. The possible synergistic action of these two chemotherapeutic agents in Friedländer pneumonia is suggested.
4. Penicillin seemed to play the major role as a life-saving therapy in this case.

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# A RORSCHACH STUDY OF SYMPTOMATIC SCHIZOPHRENIA FOLLOWING BRAIN TRAUMA

John L. Endacott, M. A.

MANTENO

The Rorschach literature dealing with the so-called "organic" diseases of the nervous system was, until recently, relatively scant.* Rorschach[27] made a few personality studies of persons with various types of organic psychoses, but he never attempted to present his findings as-a-whole in a systematic manner. Beck[1] in 1937, pointed out the paucity of information concerning these diseases. Since that time, Harrower-Erickson[13], [14], [15] has made pre- and post-operative studies of groups of patients with organic brain lesions such as tumor and focal epilepsy; Nadel[21], [22] has also reported the same type of studies on patients with brain tumors; Klopfer and Tallman[19], [20] have reported two

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*For those persons who desire more detailed information on the Rorschach test, see especially the manuals of Beck[1], Bochner and Halpern[3], Klopfer and Kelley[18], or the files of the Rorschach Research Exchange.

Rorschach studies on Brickner's[6] patient, Mr. A. who had a bilateral frontal lobectomy. The greatest amount of work in this field has probably been done by Piotrowski[23], [24] with all types of organic brain pathology, including a study[25] of one of Goldstein's[11] Pick's Disease cases. Recently, Brussel, Grassi, and Melniker[9] have made a study of postconcussion cases among the personnel of the armed forces.

In discussing the response pattern of patients with organic brain lesions, the question arises: Is there a certain pattern of responses characteristic for organic brain disease? Beck[1] is unable to distinguish any significant trends in the response pattern of "organic" patients. On the other hand, Piotrowski[23] has posited ten signs that characterize the Rorschach response pattern of an "organic" patient. Of these ten signs, six of them should appear to definitely establish a positive diagnosis of organic brain disease although the absence of the necessary number of signs does not mean that organic brain disease is not present. Piotrowski's ten signs are as follows: (1) a small number of responses — less than 15; (2) average time per response more than one minute; (3) a total of less than two movement (M) responses; (4) the presence of at least one pure color response (Cn); (5) the percentage of good form responses (F+%) below 70; (6) less than 25% of the total responses of the "popular" (P) type; (7) repetition or the giving of the same response to several ink blots; (8) impotence or the giving of a response in spite of the recognition of its inadequancy; (9) perplexity associated with distrust of one's own ability and the quest for reassurance; and (10) automatic phrases or the frequent use of a "pet" phrase in responding.

Having established a Rorschach pattern for "organic" patients in general, the next question that arises might be: Is it possible to make a differentiation between the Rorschach patterns of patients with post-traumatic lesions and frontal lobe lesions from other types of "organic" patients? Brussel, Grassi, and Melniker[9] have shown that such a differentiation is possible. Post-traumatic cases are distinguished by the presence of: (1) more than one movement (M) response; (2) some pure color responses (C) and the possibility of color shock which may vary on retesting; (3) shading responses (almost pathognomic if more than 3) (4) confabulatory responses (DW); and (5) many small detail (Dd) responses (10-25% slight, 26-32% moderate, over 50% severe lesions). Although these signs have not been established for certain, a frontal lobe lesion may possibly be established by the presence of the following signs: (1) the patient has great difficulty in relating his concept to some area of the blot, and (2) he is unable to improve his performance on a retest or when requested to do so.

Now for a consideration of the case in point. As a child, the patient received a severe trauma to the frontal bone. Years later, as an adult, she showed pronounced symptoms characteristic of paranoid schizophrenia. The question for the diagnostician is: Is this a case of "functional" paranoid schizophrenia or does the present personality picture have a causal relationship to the earlier trauma? Furthermore, even though the presence of organic pathology can be clinically demonstrated, is it possible satisfactorily to make a differential diagnosis by means of the Rorschach test? To get an answer to these questions, here are the clinical history and medical findings.*

At the time of examination, the patient was 28 years old. No hereditary trends were elicited. She was healthy to the age of 11 at which time she was struck by the pointed end of an umbrella which pierced the frontal bone above the right eyebrow. She became unconscious and was immediately operated on a depressed skull fracture which did damage to the underlying brain substance. The patient was unconscious for about two weeks, made a slow recovery, and was paretic on the left side — residual of which is still present. Her mental development appeared at first not markedly retarded. She completed grammer school and had about 1½ years of high school. The interval between the age of 11 and her early twenties was filled with long hospitalizations, orthopedic surgery, and neurologocial checkups. The findings of a pneumoencephalography in St. Luke's Hospital, Chicago, in 1938 are shown in the accompanying illustrations.** The pictures show an absence of bone in a triangular area of the right half of the frontal bone. The ventricular system is filled by means of air. The right and left anterior horns are displaced toward the right. The left one is slightly dilated. From the anterior

*I want to express my deep apprecation to Dr. W. R. Kirschbaum for aiding me greatly in the presentation of the medical data contained here.

**I want to express my gratitude to St. Luke's Hospital, Chicago, for allowing me to use their technical and medical findings for this paper.





portion of the right ventricle, air extends upward to the vertex and outward and downward between the frontal lobes and the internal table of the skull. This is due to porencephalia. There is evidence of atrophy involving the right hemisphere and in a lesser degree, the left hemisphere. From the last neurological examination, it appears worthy to mention slight disturbances in motor coordination, occasional twitching of her legs, and very rare "spells" of unconsciousness.

Her complaints started in the past five years and were marked by headaches and dizziness. Personality changes began to be discernable at the age of 23. She lost her former interest in all activities and became inactive and withdrawn. Various paranoid trends were quite marked. She thought people were watching her and that her mother was attempting to poison her food. She complained that people took her words, twisted them around into a special meaning, and said them back to her. She felt influenced by the radio. She thought her physician had influenced her and that he might have tampered with her sexual organs. Her clothes and other aspects of her environment all had special meanings for her — as an example, a red dress signified menstruation — other people were aware of her menstruation and discussed it behind her back. When the patient entered Manteno State Hospital, there was no satisfactory anamesis and her organic findings were much less pronounced than they are now.

This patient was given the Rorschach test on 1/26/42 and retested on 4/1/43 — 15 months later. The results on the retest were practically the same, indicating a degree of reliability in the test findings, except for two important changes.

The large number of responses (R—67, 85)* given by this patient would seem at first glance to reflect a great amount of personality productivity. Over half of these responses were perseveration on human detail responses (Hd% —58, 63) and when "allowance" is made for this, the productivity falls more or less within "normal" limits. On both tests, the average time per response was less than thirty seconds. The low percentage of good form (F+%—63, 37) in the responses indicates that the patient has poor intellectual control and that she is not in good contact with reality. Here we should note a distinct decline in the percentage as between the first and second tests. Another clue to the quality of "thinking" is the number of movement responses (M—5, 1) which reflects the capacity for producing creative fantasy. On the first test, the patient showed a "good" capacity for creative fantasy but on the second test, this had largely disappeared, accompanied by a slight increase in animal movement responses (FM—1, 2). Schizophrenic or delusional thinking is revealed in the production of confabulatory responses (DdD—3, 6); there was an increase in this type of response on the retest. This whole trend reflects a distinct trend

*In presenting the precise numerical findings for each of the scoring categories which are in parentheses, the first number is the result on the first test; the second number is the result on the retest.

toward an impoverishment of mental life — a trend toward deterioration.

Emotionally, the patient's responses show an increasing trend toward "instability." The presence of color-form responses (CF—2, 3) indicate that she is emotionally impulsive, irritable, and suggestible.*

This is not balanced by enough of the form-color responses (FC—2, 0) which reflect an emotional life that is in good rapport with the demands of reality. A comparison of the two tests shows an increase in the color-form responses and a decrease in the form color responses. The production of three shading responses on each of the two tests reveals some feelings of personal inferiority, anxiety, and perhaps depression.

One of the most striking and interesting features is that out of all her responses, she was unable to give a single whole response. This is unusual as most persons can produce at least one or two whole responses on the first five or six blots. The patient produced, instead, a fair percentage of detail responses (D%—49, 42) and a very high percentage of small detail responses (Dr%—51, 51). This indicates that she is able to respond to only very limited segments of the world around her. This same trend is reflected in the low organization score (Z score—9.5, 12) which shows little ability to see relationships.

There are a number of studies[1], [2], [10], [16], [18], [26], [27], [29] on the responses of schizophrenics on the Rorschach test. In this case, there are many signs that suggest the pattern of a schizophrenic personality. These are: the low percentage of good form, confabulatory responses, a variability in the quality of the responses, low percentage of popular responses (P%—3, 6), the presence of some responses that referred directly to the patient, perseveration, and the ratio of movement and color responses. Ordinarily, in schizophrenics, there is a predominance of color responses but in paranoids there is a predominance of movement responses. The first record reflects the distinct paranoid nature of the disease.

Although the test results reveal this schizophrenic pattern, closer analysis indicates that this is predominately an organic case. Seven of Piotrowski's ten signs are present. They are: total of less than two movement responses (this was true of only the retest), low percentage of good form, low percentage of popular responses, repetition, impotence, perplexity, and automatic phrases. The last-named signs were evidenced in part, by the fact that the patient would repeat rather helplessly from time to time, "All I see is faces," and add, "I don't seem to see much else."

Post-traumatic lesions were revealed by the presence of more than one movement response (this was true of only the first test), three shading responses, confabulatory responses, and very many small detail responses. According to Brussel, Grassi, and Melniker[9], the high percentage (51%) of small detail responses emphasizes the severity of the lesions. Lesions of the frontal lobes are indicated by the patient's "poorer" not "better" performance when retested, and because of her great difficulty in relating her response to the blot. Time and time again, she would say that she saw a face but when asked to locate it, she would pick out some tiny part of the blot and say that the face was there, but she was unable many times to relate any of the parts of the face to any part of the blot.

We are often confronted with the problem of an organic case that shows schizophrenic-like features. From the standpoint that one considers that all problems concerned with thinking and behavior involve an underlying physiological correlate, one can agree with the psychologist, J. F. Brown[8] that, "Every behavior problem is at the same time a physiological, or organic-medical, and a psychological or psychiatric problem." The problem for the psychiatrist or psychologist is the one of the relative emphasis to be given to the organic and functional aspects. In spite of the fact that the physician may often succeed with his clinical approach, there are cases left where the psychologist may make a definite contribution toward arriving at a diagnosis.

An old persistant problem which is similar to the one presented in this paper, is that of the paranoid hallucinatory states often seen after malaria treatment in general paretics.* By the

*The patient gave no pure color (C) or color naming (Cn) responses.

*See Bostroem[4], [5], Rothschild[25], and von Angyl and Gyarfas[31].

use of the Rorschach test, we may throw some light on the problem of whether or not the paranoid process is the result of a "true" schizophrenic process or whether it is causally related to known underlying organic pathology.* This same problem is also present with respect to alcoholic hallucinatory states and in special presenile and senile psychotic symptoms.

Not only in this case of brain trauma, but in all the above-mentioned organic diseases, speculations arise as to the production of schizophrenic-like symptoms and their localization in the frontal lobes. Our case gives a fairly good insight into some aspects of frontal lobe functioning. The Rorschach test reveals that this patient is able to react to only very limited aspects of her environment; her ability to perceive and react to large integrated wholes or total situations has been lost. Coupled with this pedantic pre-occupation with details, we have seen the growth of a schizophrenic type of thinking. She reacts to some detail of her environment as if it were a larger whole or situaion. As an example, she says in effect, "People are talking, hence, they are talking about me," or, "The dress is red, hence, it refers to menstruation."

Brickner[6, 7], Grinker[12], and Tilney and Riley[30] have pointed out that it is in the frontal lobes that our thoughts are "synthesized" or organized. The fundamental theoretical assumption is the old mechanistic one that mental activity is a matter of organizing or associating discrete bits of experiences into a meaningful whole or pattern. The author prefers to use the more Gestalt or organismic terminology of R. H. Wheeler[32] who says that all experience and all things in nature are already organized. The problem for the psychologist then is the qualitative and quantitative structure of a situation to which one is capable of reacting. We have seen that this patient is capable of reacting to only a very limited situation as she has lost her capacity for "synthesizing" or reacting to large complicated situations because of her frontal lobe damage. The growth of the schizophrenic process is related to this pre-occupation with details of her environment as we have seen that she reacts to a detail of a situation as if it were the total situation. These findings, then, would seem to suggest that "thinking" and schizophrenia are primarily matters of frontal lobe localization.

*Kenyon, Lozoff, and Rapaport[17] have used the Rorschach test to give a personality picture of this type of patient before and after metrazol treatment.

## SUMMARY

1. The use of the Rorschach test in the field of organic brain disease was discussed.

2. The history and clinical findings were presented.

3. The Rorschach results were presented and a differential diagnosis was made.

4. Certain implications for frontal lobe functioning were discussed.

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DISCUSSION

Phyllis Wittman, Ph.D. (Elgin): Mr. Endacott's Rorschach evaluation of the case presented is a very interesting one although difficult to discuss since it is a descriptive analysis of just one case.

However, the main question that occurs to me is why the diagnosis of paranoid schizophrenia should be brought up at all, in this case. The patient has a history of severe brain trauma seventeen years previous, with a left-sided paralysis as a sequella, which I gathered is still present. Five years previous to State hospitalization, she complained of headaches and dizziness, and certain personality changes were noticed at that time.

That this organic process appears to be a progressively deteriorative one is evidenced by the fact that at the present time she has disturbances in motor coordination, occasional twitching of her legs and periods of unconsciousness as described in the paper. Consequently, it would seem to me that Morgan's law of parsimony alone requires the diagnosis of organic brain disease with psychosis and rules out the diagnosis of functional schizophrenia even without the aid of the Rorschach findings.

We know that many organic cases, — paretic, arterio-sclerotic, and epileptic, — as well as cases of organic brain disease may show psychotic symptoms similar to those considered characteristic of schizophrenia. We would not, however, for this reason consider diagnosing the syphilitic meningo-encephalitic as a case of functional schizophrenia.

In other words, the problem does not appear to me to be "the relative emphasis given to the organic and functional aspects" but merely a problem of emphasizing the etiological factors which in this case seem fairly clear.

The value of the Rorschach test would have been more convincingly demonstrated in this case if a diagnosis of organic brain disease had been made in the absence of anatomical or neurological evidence and if this Rorschach diagnosis had been subsequently verified.

In view of the patient's inability to react to integrated wholes or total situations on the Rorschach, it would be interesting to see if her reaction to such tests as the Haufman Kasanin Concept Formation scale and the various tests of abstract thinking used by Cameron, Goldstein, Halsted and others would not also yield results pathognomonic of an organic brain condition.

C. A. Neymann (Chicago): Whenever this type of a discussion takes place it leaves me somewhat mystified. To say the least it is peculiar that medical men and especially psychiatrists have not delved into the root of the evil of nomenclature. On rife deliberation one must come to the almost inevitable conclusion that all nomenclature is purely artificial.

It would seem that it makes little if any difference whether a patient is classified as a schizophrenic with manic features or as a manic with schizophrenic features. From a broader viewpoint it does not help the patient one whit to be dubbed either manic depressive or schizophrenic.

It is more than academic, it is purely medieval mysticism to try and distinguish between organic brain disease resulting in schizophrenic features and organic brain disease with a super-

imposed schizophrenia, perhaps the result of some vague psychogenic trauma.

All this is just a play on words. The important thing is that the patient has developed an organic brain disease; that this organic brain disease is progressive; and that during the progress of the disease the patient expresses various bizarre ideas. Whether one calls these symptoms schizophrenic or manic depressive or anything else remains a pure psychic gesture.

Whenever an organic brain disease produces psychopathological thoughts, or symptoms these react along the lines of the individual's least mental resistance. Thus, as is well known, a general paretic, who develops a psychosis will follow the pattern of his personality in his psychosis.

It would seem to be very doubtful whether this Gordian knot produced by such ingenuous quibbling can be unraveled by the Rorschach test. The Rorschach test was standardized on neurotic and psychotic, feeble-minded, bizarre and so-called average individuals. These had been classified by a psychiatrist. Previous to this he had convinced himself that these types represent clear cut outspoken entities.

My own experience has taught me this. The Neymann-Kohlstedt test was formulated on the same basis. It is but an expression of what I think of the schizophrenic and manic depressive problem.

Therefore, the entire discussion, though interesting, is less valuable than a clear description of the patient's symptoms which would be much more informative and helpful.

J. L. Endacott, M.A., Manteno (closing): I should perhaps have explained to Dr. Wittman that a ten minute time limit prevents my saying much, and had it not been for brevity of time, I should have said that in diagnosing such a case we knew that on one hand here is the organic injury at the age of eleven and on the other here are the schizophrenic symptoms at the age of twenty-eight. Now are we justified, on the strength of that in presuming that the schizophrenic symptoms are therefore on an organic basis? If the schizophrenia had come on somewhat sooner after the original trauma, the problem would have been much different.

Also we should not overlook the fact that in this case there are possible psychogenic features involved, — the fact that she had all these hospitalizations, the sexual content of her delusions which might have been rather meaty for a psychoanalyst, and so forth. There are various things then to indicate that there are some psychological as well as physiological factors involved.

Some persons perhaps would find it easy to say, "Well, this is organic brain disease — here is the trauma at age eleven." But at the same time, when we made the diagnosis we weren't quite sure whether we were justified in assuming that since the cause and the effect were spread so far apart in time, the cause and effect did have a positive relationship.

Also I would like to point out in this connection, as has been pointed out before, that when one does get an organic brain disease, the disease many times follows the general pattern of the personality. For instance, it is well known that about ten percent of all individuals go into a state hospital. About ten percent of all syphilitics develop paresis. It has been said that persons who become paretic are merely individuals that would have become psychotic anyway, and that the spirochete merely is implicated in a little bit of what has been called "somatic compliance."

I don't defend that statement; I merely point it out.

In answer to Dr. Neymann, I would like to say that his remarks are quite well taken, too. I do think too much can be said for what the Rorschach test can do. I think that it can only aid in cutting this Gordian knot; I don't think it is any panacea or any last minute answer to any problem. On the other hand I think it is one of the most fruitful techniques we have at present and that it has certain definite advantages over pencil-and-paper tests, but that is another problem which we shouldn't discuss here.

All in all I appreciate the remarks and consideration of the various discussants who have made remarks on my paper.

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## HUMAN ORNITHOSIS

### Report of Case Treated with Penicillin

Tom Kirkwood, M.D.

LAWRENCEVILLE

This disease was first described by Ritter in Switzerland in 1879. He noticed that it occurred in homes where birds were kept as pets. Finding the patients in a typhoid-like state but with definite pneumonic changes, he called the disease "Pneumotyphus". In 1892 the disease appeared in Paris following the importation of parrots from South America. Paris had another outbreak in 1894 which caused many deaths. It was quite evident by this time that the infection was definitely associated with exposure to tropical birds of the parrot family, so Morange suggested psittacosis as a suitable name for the disease. Later investigation showed that other tropical birds of the psittacine species such as parakeets, love birds, budgerigars, cockatoos, and

macaws could be infected and could transmit the disease. "Ornithosis" has recently been suggested as a name for the infection when acquired from birds not belonging to the psittacine group.

In 1929 and 1930 one hundred and sixty-nine cases of psittacosis were reported in the United States following the importation of diseased parrots from South America. The mortality in this group was nineteen percent. During this period a great amount of research work was done on various phases of the infection in this country and in Europe. Different organisms had been suspected as the causative agent but none had been definitely found guilty. In 1930 Bedson and several other investigators showed that a filtrable virus was the true infective agent. In 1930 Krumwiede and associates showed that white mice could easily be infected with this virus. In 1930 and 1932 Rivers and Berry infected monkeys with the virus, producing the typical pneumonic changes, and also used mice in testing for the virus in human sputum. Mice were used recently by Heilman and Herrell at the Mayo Clinic in checking the therapeutic value of penicillin in this infection. Forty mice were inoculated with the virus and soon afterward received penicillin which was continued for seven days. The mortality in this group was five percent. A control group of forty mice were inoculated with the same virus but received no penicillin. The mortality in this group was eighty-eight percent.

The virus is found in the nasal and bronchial secretions and in the droppings of infected birds. It is capable of standing prolonged drying and can be carried considerable distances by air currents, thus possibly transmitting the infection.

It was generally assumed that only birds of the parrot family harbored the infection, until 1941, when Dr. Karl Meyer found a virus, similar to that causing psittacosis, in the lungs of a patient who was exposed while caring for a flock of homing pigeons. Sixty-three percent of the birds in this group showed positive complement fixation tests and the virus itself was isolated from twelve percent. Dr. Meyer also showed that canaries may harbor the disease. Chickens, doves, finches and the common barnyard pigeon can be infected and may transmit the disease. Dr. Meyer states that the infection never spontaneously disappears when once established in a group of birds. He suggested using the name "Ornithosis" for infections acquired from birds not belonging to the psittacine group. The pigeon is apparently the most common carrier. Until recently all human cases caused by pigeons have been reported from the Pacific and Atlantic Coast States. Turgasen of Manitowoc, Wisconsin, reported a case occurring in August 1944 in a pigeon fancier, who had inhaled considerable dust while cleaning the loft where his homing pigeons were kept. The case reported below occurred in December 1944 after a contact with common pigeons killed along the Illinois-Indiana line. Hence the disease is now established in the Middle West. Both of these cases were treated with penicillin and according to Dr. Herrell of the Mayo Clinic were the first in which this treatment was used.

Pigeon flocks wander from farm to farm and from town to town. This makes it easy for them to spread the infections. Their droppings may contaminate farm feeding lots and cause infection to poultry. Hogs are susceptible to respiratory diseases and it is possible that ornithosis virus in contaminated feed lots may be responsible for some epidemics occurring in these animals.

Psittacosis or ornithosis causes a group of symptoms and other findings, which are very similar to those associated with pneumonias of non bacterial origin usually referred to as "primary atypical pneumonias" or "virus pneumonias". The possible relationship of these pneumonias and ornithosis opens up an interesting field for investigation. In 1943 Smadel reported that 25% of the atypical pneumonias which he had studied were due to psittacosis virus. Meyer says, "with such a vast reservoir of ornithotic virus available everywhere, one wonders why many sporadic atypical pneumonias are not in some way connected with these sources". Since 1935 primary atypical pneumonias have been variously referred to as acute influenzal pneumonia, acute pneumonitis, disseminated focal pneumonia, acute interstitial pneumonia, virus pneumonia and atypical broncho pneumonia. The lung changes in these cases and in ornithosis are mostly interstitial in character with the lesions being found in and around the walls of the bronchioles and alveoli. The incubation period in ornithosis and in the

atypical pneumonias averages from one to two weeks. The symptoms and signs are much alike in both diseases. The onset is much like that of influenza and is usually sudden but may be gradual. The pulse and respiratory rates are slow compared to the fever range and this is particularly true in ornithosis. The physical findings in the lungs are minimal at first. However the x-ray films show accentuation of the hilar shadows early in the illness before physical examination discloses anything. Later the hilar shadows fan out towards the periphery especially in the lower lobes. Fine moist rales may be heard at this time over the involved areas and changes in the breath sounds may appear. Pleural pain is rare. Cough is often entirely absent in the early phases of the disease. In some cases it is productive and very annoying in the later stages. The patients are often very nervous, complain of violent headaches, are restless and delirious and get little sleep. Abdominal distress and constipation are common. The tongue frequently shows a thick white coat. The average duration of the attack is about two weeks but may extend to four or five weeks in severe cases. Rapid pulse and respiratory rates indicate a bad prognosis. The changes in the lungs are easily missed entirely if the x-ray is not used, the patient and the doctor both thinking that the condition is a mild or moderate upper respiratory infection or influenza.

Report of Case: Mrs. E. L. C., a white woman aged 52, cleaned and dressed six barnyard pigeons on November 24, 1944. One thumb was punctured by a bone splinter while cutting off a wing. There was no inflammatory reaction around this puncture and it probably had no bearing on the infection which followed. On December 2nd, eight days after dressing the pigeons, she suddenly became very ill, had chilly sensations, general malaise and severe headaches. The general physical examination was essentially negative and no diagnosis could be made. Tularemia was considered as she had also dressed quails and rabbits in November. No primary ulcer or enlarged lymph nodes were present which eliminated anything except the typhoid type of tularemia. Subsequent agglutination tests up to six weeks after the attack ruled out this disease. Her fever ranged from 101 to 105 with no change in physical signs whatever until December 10th, when a few moist rales were noticed in the right lung posteriorly near the angle of the scapula. By December 12th there was a distinct area of consolidation about the size of a silver dollar in this region. Moist rales were heard around this area. The cough was slight and non productive. There was no pleural pain whatever. Other than the physical signs there was nothing to make one suspect any pulmonary disorder. Restlessness, nervousness and headache dominated the picture. There was considerable mental confusion and delirium and the patient appeared to be very ill. The respiratory rate and pulse were slow throughout the illness. The pulse once reached 128 when the temperature was 105. The respiratory rate was rarely over 20. The RBC count was 3,500,000 and the hemoglobin 60%. The white blood cell count was never over 8000. Blood samples were sent to Dr. K. F. Meyer, University of California, who reported that the sera specifically fixed complement in serum dilution of 1:128 (4 plus) and 1:256 (3 plus) when tested by the complement fixation test with psittacosis antigens.

During the early part of the illness the patient received adequate doses of sulfadiazine without effect. Other drugs had only a palliative effect. One ASA compound capsule every 2 hours helped to allay the headache and control the fever. If these capsules were left off the fever soon reached 104 or 105 degrees. Penicillin was started at 10 P.M. on the 10th day of the disease. The fever was 105 at the time and was still 104.5 at 7 A.M. the next morning, after which it dropped rapidly. She received 20,000 units, followed by 10,000 units every 3 hours until 500,000 units had been given. Within 48 hours the temperature was running between 99.5 and 101 degrees and in another 48 hours it was normal and remained so. The patient's sense of well-being improved as soon as the penicillin was started. The troublesome headache and restlessness soon disappeared. This improvement may have been purely coincidental, but the rapid recovery in such a severe and alarming infection, following the use of this drug, makes me feel that it should be tried in infections of this type in order to determine its status. The improvement in this case and in that reported by Dr. Turgasen indicate that we may have a remedy in penicillin which will reduce the death rate in this disease.

This patient's recovery after the penicillin was started was uneventful. The lung involvement cleared up rapidly. However she was very slow in recovering her strength, being confined to bed for four weeks. She had a mild microcytic hypochromic anemia prior to her illness which increased while she was ill. This quickly disappeared on using iron.

## CONCLUSIONS

1. Pigeons in this part of Illinois and Indiana are infected with ornithosis virus.

2. These birds roam at large over the country side and may infect other pigeon flocks, poultry and possibly other livestock on the farms.

3. Any individual handling the infected birds or inhaling dust contaminated by their droppings may acquire the disease. Poultry and farm ani-

mals may also prove to be a source of infection.

4. In any acute lung infection which proves to be of non bacterial origin (atypical or virus pneumonias), psittacosis or ornithosis should be considered.

5. Penicillin may prove to be of great value in controlling the disease.

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## X-RAYS SHOW UNBORN CHILD OF 12 WEEKS BREATHES, SWALLOWS

### Two Chicago Doctors Demonstrate Beginning Of These Important Functions In Two Groups Of Pregnant Women

Two Chicago doctors have demonstrated by means of a dye and x-rays that the important functions of breathing and swallowing develop as early as the 12th week in an unborn child.

Writing in the August 10 issue of *The Journal Of the American Medical Association*, the authors—M. Edward Davis and Edith L. Potter from the Department of Obstetrics and Gynecology, the University of Chicago School of Medicine and the Chicago Lying-in Hospital — state that these experiments were carried out on two groups of patients: one made up of 16 women, who because of some serious maternal complication, had to have their pregnancy terminated in the first half of the period and the second consisted of 10 women who were delivered by a cesarean operation.

The dye, opaque to x-rays, was injected into the sac containing the fetus. From 17 to 52 hours later the pregnancy was terminated and the fetus was sent to the x-ray laboratory. The first group of fetuses showed the dye in all parts of the lungs, in the stomach and throughout the intestinal tract, demonstrating that the fetus aspirated the fluid within the sac and exhaled it. Thus there is evidence that the fluid normally moves in and out of the lungs.

The second series of patients, who were delivered by cesarean operation, were treated in the same manner. X-ray examination of the infants' lungs immediately after delivery showed evidence of the dye in five, probable presence in two and no definite evidence in three.

The authors point out that the "general pattern of respiratory activity is developed very early in fetal life.) During this period the respiratory movements are intermittent, irregular and shallow. "At birth air is substituted for fluid, and respirations become deeper, regular and continuous, but the pattern remains the same. The major change involves the substitution of air for fluid as a medium of exchange."

In Conclusion Drs. Davis and Potter state that "fetal swallowing and complete gastrointestinal activity has been demonstrated for the first time in a human fetus (12 weeks old) weighing 39 grams."

# News of the State

## PERSONALS · COMING EVENTS · MARRIAGES · DEATHS

### POST-GRADUATE CONFERENCES

ROCKFORD, ILLINOIS
OCTOBER 9, 1946
NELSON HOTEL

Anfin Egdal, M. D.-Presiding

2:00-3:00 P.M. — Carlo Scuderi, M. D. —"Repair of Major Bone Defects by Bone Graft Surgery"

3:00-4:00 P.M. — I. Treiger, M. D. — "Frequently Encountered Heart Conditions"

4:00-5:00 P.M. — Carl A. Dragstedt, M. D. — "Therapeutics of the Newer Drugs"

5:00-6:00 P.M. — Hans H. Reese, M. D. — "Trends and Progress in Neurology and Psychiatry"

6:30-7:30 P.M. DINNER at the Nelson Hotel — Doctor Edward H. Weld, Presiding

8:00P.M. — Address on "Surgical Problems of General Interest"—Lester R. Dragstedt, M. D., Professor of Surgery, University of Chicago.

Local Committee in charge of arrangements:

J. Howard Maloney, M. D. — Chairman
E. H. Quandt, M. D.
D. H. Wrork, M. D.
Arthur Pearmon, M. D.
P. A. Anderson, M. D.
Fred Norten, M. D.

All doctors of northern Illinois are cordially invited to attend this meeting. The program has been planned to appeal to men in general practice.

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QUINCY, ILLINOIS
OCTOBER 10, 1946
LINCOLN-DOUGLAS HOTEL

Dr. Walter Stevenson, Presiding

2:00-2:45 P.M. — "Common Fractures"

2:45-3:30 P.M. — "The Diagnosis and Treatment of Common Blood Disorders"

3:30-4:15 P.M. — Surgical subject

4:15-5:00 P.M. — "Therapeutics of the Newer Drugs"

5:00-5:45 P.M. — "Coronary Disease"

6:30 P.M. —Social and Dinner Hour

8:00- Robert S. Berghoff, M. D. — President, Illinois State Medical Society

Harold M. Camp, M. D. — "Where Do We Go From Here" — Secretary Illinois State Medical Society

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### BUREAU COUNTY

Dr. J. W. O'Malley who served in the army two and one-half years will reopen his office in Ohio, Illinois, this fall.

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Dr. Nicholas Chick after three years service in the army has opened an office in Spring Valley for the practice of medicine.

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### CARROLL COUNTY

Savanna has been selected for a state tuberculosis sanatorium authorized by the general assembly at the last regular session. The legislature authorized the construction of five sanatoriums, specifying that one should be located in Cook County and four down state.

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Dr. Ruth E. Church has assumed her duties as director of district health unit three, Illinois Department of Public Health, Savanna.

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### CHAMPAIGN COUNTY

Dr. Cyrus F. Newcomb, Champaign physician, will continue to serve as acting director of the Champaign-Urbana Public Health District.

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### COOK COUNTY

Dr. Cornelius W. Vermeulen was recently appointed associate professor of surgery at the University of Illinois College of Medicine. Dr. Vermeulen received his M.D. Degree from the University of Chicago in 1937 and served as an instructor in surgery at that university until he left for army service in 1942. At the time af his discharge last spring he was chief of surgical ser-

vice at the army air force Regional Hospital in Amarillo, Tex. Dr. Vermeulen is the author of a number of articles in the field of urology.

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Dr. Charles Edwin Galloway addressed the Iowa and Illinois Central District Medical Association in Davenport, Iowa, on September 12th on the subject of "Treatment of Abortion."

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Dr. Richard H. Young, physician to Northwestern University and Director of student health, has accepted the deanship of the school of medicine at the University of Utah. He will assume his new duties this fall.

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Dr. Victore Lespinasse, a faculty member of Northwestern University Medical School was honored by the American Urological Association at its 41st annual convention in Cincinnati for her research work in cancer of the kidneys.

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The first refresher institute for occupational therapists was held at the University of Illinois College of Medicine on August 15th.

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Dr. Walter G. Maddock and Dr. Bertha A. Klien have been appointed associate professors of surgery and ophthalmology respectively at Northwestern University Medical School. Dr. Maddock was recently released from military service, and Dr. Klien has been serving as associate professor of ophthalmology at the University of Illinois College of Medicine.

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The Dr. Leonard H. and Louis Weissman, Medical Research Foundation was recently organized to perpetuate the memory of Dr. Leonard H. Weissman, formerly assistant administration officer of the Cook County Hospital, and his brother Louis Weissman, both of whom were killed in airplane accidents over Germany during World War II. The funds that are collected by the group organizing and carrying on this corporation, which is organized as a nonprofit corporation under the laws of the state of Illinois, are to be used for medical research. The foundation is closely connected and allied with the Hektoen Institute. On June 26 the foundation donated $5,000 to the Hektoen Institute to be used for medical research on rheumatic heart fever. Dr. Weissman's obituary appeared in The Journal July 13, page 934.

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Dr. Herman Smith, director of the Michael Reese Hospital since 1920, has resigned, effective on the selection and appointment of a successor. Dr. Smith, who will continue to live in Chicago, will devote his full time to his private practice as a consultant to hospital boards and architects in hospital planning and building, and also as a consultant to hospital boards in hospital administration.

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The Illinois Society for Mental Hygiene announced that begining July 1 all inquiries regarding individual problems and the use of psychiatric facilities and resources in such cases would be handled in the offices of the Community Referral Service. The Illinois Society for Mental Hygiene will continue to serve as a clearing house on subjects relating to mental hygiene and to comply with requests for specialized information to individuals and groups with particular interests or responsibilities in this field. The mental hygiene society is located at 343 South Dearborn Street and the referral service at 105 West Adams Street, room 230.

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Dr. Jay A. Myers, Minneapolis, will address the Chicago Tuberculosis Society at the Bismark Hotel, October 24, on "Early Tuberculosis." Dr. Hugo T. Cutera is secretary-treasurer of the society.

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Dr. William B. Wartman, who served as a lieutenant colonel in the medical corps, A. U. S., during the war, has been appointed Morrison professor of pathology and chairman of that department in the Northwestern University Medical School, it was announced August 5. Dr. Wartman, who graduated at the University of Pennsylvania School of Medicine, Philadelphia, in 1932, served on the staff of Western Reserve University School of Medicine, Cleveland, in 1935-1941, becoming pathologist in charge of the university hospitals in 1939.

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A 35 million electron volt betatron, a machine invented for study of atomic power, will be constructed this fall for use in cancer research at Michael Reese Hospital. The Chicago *Sun* in reporting an interview with Dr. Erich M. Uhlmann, director of the tumor clinic at the hospital, reported July 19 that new vistas in the war on cancer opened as a result of betatron experiments at the University of Illinois. With the recent disclosure that a free beam of electrons had been successfully released three weeks ago from the 22 million electron volt betatron at the university, possibilities were foreseen, among others, of creating artificial radioactive substances and of attacking deep seated cancer. Dr. Uhlmann stated that it would take possibly five years before he would have terminated experiments on biologic objects and animals and begun using the betatron on human beings. "Liberation" of the free beam of electrons terminated nine months of work directed by Lester S. Skaggs, Ph.D. physicist of the tumor clinic at Michael Reese, who was on loan to the University of Illinois.

The Army Commendation Ribbon was recently awarded to Lieut. Col. Maurice A. Walker, formerly of Chicago, "for meritorious service as safety consultant, Baxter General Hospital, Spokane, Wash., from Jan. 1, 1944 to Oct. 15, 1945. In addition to his duties as chief of surgical service Lieutenant Colonel Walker was responsible for conducting and maintaining a safety program which, through his zeal and unremitting efforts, resulted in an outstanding record of 4,312,316 man hours of work accomplished without loss of time due to accidents. His superior performance of duty contributed materially to the welfare of employees at this hospital." Dr. Walker graduated from Rush Medical College, Chicago, in 1928 and entered the service Sept. 12, 1942.

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Dr. Warren H. Cole is serving as acting dean of the University of Illinois College of Medicine and executive dean of the Chicago Colleges until Dr. Andrew C. Ivy assumes his position as vice-president, September 1.

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Dr. Robert R. Mustell has been invited to address a Conference of the Illinois Federation of Women's Clubs on September 28th.

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Dr. Mitchell L. Krupinski will talk before the Richard Yates Parent Teacher Association on October 1st on the subject "Youth is the Future in a Healthier World."

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Dr. Arthur H. Rosenblum will address the James Madison Parent Teacher Association October 15th speaking on "Your Child's Heart."

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Dr. George A. Hellmuth has been invited to address the Windsor Park Woman's Club on October 22nd. He will discuss "Heart Disease."

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Dr. M. A. Perlstein has been invited by the Michigan Society for Crippled Children to hold institutes on cerebral palsy in Grand Rapids and in Kalamazoo, Michigan, on November 7, 8 and 9.

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Dr. Herbert E. Schmitz will address the Southern Illinois Medical Society on November 14th, subject, "Cancer of the Uterus."

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## FRANKLIN COUNTY

Dr. Grover C. Chamness who had planned to practice in Lovington has cancelled his plans and has decided to locate in Ziegler.

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## GRUNDY COUNTY

Dr. Elliot M. Tratt resumed his medical practice in Morris recently taking over his old office he occupied before the war.

## HENRY COUNTY

Dr. C. Paul White addressed the Rotary Club of Kewanee August 6th, subject, "What a Physical Examination Means To You."

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## JEFFERSON COUNTY

Dr. Louis Emmerson Ward has returned to Mount Vernon after serving two and one-half years in the army medical corps.

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Mount Vernon is one of the four downstate locations chosen for a state tuberculosis sanatorium as authorized by the general assembly.

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## KANKAKEE COUNTY

Dr. Charles W. McMillin after 43 months of service in the medical corps, Army Air Forces, has returned to Kankakee and opened a new office for the practice of his specialty, eye, ear, nose and throat.

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## LA SALLE COUNTY

LaSalle County Medical Society arranged a cancer porgram for their September 12th meeting. Dr. Danely P. Slaughter presented "Cancer of the Breast" and Dr. Warren H. Cole spoke on "Cancer of the Stomach."

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Dr. Howard Hamlin, chief of the neurosurgical laboratory at Mayo General Hospital, spoke before the Nazarene Church of Ottawa on Sunday, July 7th. Dr. Hamlin is under appointment for medical missionary work in China and expects to sail in the near future.

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Dr. Charles E. Radliff who served nearly 4 years as an army medical officer, was recently elected commander of the Peru post of the American Legion.

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## LEE COUNTY

Dr. Horace Dunn has opened an office in Franklin Grove for the practice of medicine. Dr. Dunn has been company physician for the Milwaukee railroad at Ladd and Granville for 30 years and also served as industrial surgeon for several Rockford industries for a period of about 3 years.

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## MACOUPIN COUNTY

Dr. Pliny A. Adams, formerly of Downers Grove, Illinois, opened an office in Staunton for the general practice of medicine.

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## McLEAN COUNTY

The Educational Committee arranged a program for the Illinois State Normal University to be presented October 10th; two talking films were secured, "Hygiene of Swimming" and "Life History of the Rocky Mountain Wood Tick."

## MADISON COUNTY

Dr. Leslie D. Darner, Granite City, who has been confined to his home because of a leg injury, is much improved.

## MORGAN COUNTY

Dr. George L. Drennan of Jacksonville, has been appointed a member of the Advisory Committee on Child Health Service, American Academy of Pediatrics.

Dr. Harlan English, Danville, chairman of the Illinois State Medical Society Committee on rural medical services addressed a conference at MacMurray College recently. His subject was "Problems of Adequate Medical Care and Services for Rural Communities."

Dr. George E. Moore, formerly of Jacksonville, who served with the U. S. Medical Corps with the rank of Lieutenant colonel, has recently been awarded the Legion of Merit.

## OGLE COUNTY

Dr. and Mrs. R. S. Johnston of Chana, recently celebrated their 40th wedding anniversary. Dr. Johnston has practiced medicine at Chana for the past 30 years.

## PERRY COUNTY

Dr. and Mrs. J. S. Templeton of Pickneyville, became the proud parents of a six pound baby girl recently. Dr. Templeton is a past president of the Illinois State Medical Society and has been practicing medicine 48 years.

## RANDOLPH COUNTY

The doctors of Randolph County Medical Society entertained the editors of the county at a dinner meeting at Dreamland Cafe in Sparta on July 31st.

## ROCK ISLAND COUNTY

Dr. Harold M. Camp, Secretary of the Illinois State Medical Society, addressed the Moline Rotary Club on August 12th, subject "Recent Developments in Medicine."

Dr. Clement P. O'Neill, Rock Island, has been invited to address the Woman's Club of that city in September on the subject of Cancer.

## STEPHENSON COUNTY

Dr. Eugene Vickery has returned to Lena to resume his medical practice.

## VERMILION COUNTY

Dr. Henry Lattuda will be associated with Dr. Jean Moore and Dr. H. F. Hooker in the new clinic in Danville. Dr. Lattuda will specialize in obstetrics and gynecology.

# DEATHS

Harvey V. Anderson, Westfield; Bennett College Eclectic Medicine and Surgery, 1914. Practiced many years in Westfield until ill health forced him to retire. Spent the last few years of his life at Otterbein Home, Dayton, Ohio. Died July 14th, aged 80, of carcinoma of prostate.

Mary Ella Ash, Galva; College of Physicians and Surgeons, Chicago, School of Medicine of the University of Illinois, 1903. Died in St. Petersburg, Fla., April 20, aged 71, of cerebral hemorrage.

George W. Bowman, Alsey; National University of Arts and Sciences Medical Department, St. Louis, Mo. Had practiced medicine in Scott County for 62 years. Died August 13, aged 88.

Rachel H. Carr, Wilmette, retired; Northwestern University Woman's Medical School, 1887. Was second woman intern at Cook County Hospital. Started practice of medicine in Chicago in 1889. Died in St. Francis Hospital, Evanston, August 13, aged 90.

Gilbert S. Cough, Mt. Carmel; Eclectic Medical College, Cincinnati, Ohio, 1897. Died recently, aged 76.

Louis Faulkner, Chicago; Chicago Homeopathic Medical College, 1896 and University of Illinois College of Physicians and Surgeons, 1904. Former head of the department of obstetrics in West Suburban Hospital. Died August 6, aged 73.

Louis J. Gay, Chicago; Rush Medical College, 1902. Was veteran of World War I. Died July 24th, following a brief illness which developed after a fishing trip near Eagle River, Wisconsin. He was 55 years of age.

Samuel A. Geraci, Chicago; Loyola University School of Medicine, 1926. Died suddenly in August at the age of 47.

Edward Henry Johnston, Chicago; Loyola University School of Medicine, 1918. Died of a heart attack, July 26th, aged 52.

Tullius Blaine Lewis, Hammond; Hering Medical College, 1907. Died suddenly in Jarman Hospital, Tuscola, July 9th at the age of 64.

Morris Lieperman, Chicago; Chicago College of Medicine and Surgery, 1917. Had practiced 23 years as pediatrician in Chicago; died while making a call, July 25, at the age of 56.

Clifford O. McCreedy, Aledo; Chicago Medical College, 1934. Was killed in an automobile accident, August 8th. He was 41 years old.

Joseph F. Meloan, Abingdon; Barnes Medical College, St. Louis, Mo., 1897. Died following a stroke July 25 at the age of 76.

John Weir, West Union; Kentucky School of Medicine, Louisville, 1892. Died suddenly in his home, July 19th, at the age of 78.

Joseph Frank Wilson, Versailles; Barnes Medical College, St. Louis, Mo., 1899. Had practiced medicine in Versailles for 45 years. Died July 31, following an illness of several months. He was 70.

# PALATABILITY AND NUTRITION FACTORS



*of*

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***Q. What is the importance of palatability?***

*A.* A leading pediatrician has pointed out that even in the early months of life infants are able to detect minute differences in flavor. The appealing palatability of Campbell's Strained Baby Soups is, therefore, an advantage. It should further be pointed out that all the "tastes" in these soups are the wholly natural ones of the meats, vegetables and cereals used.

***Q. Why are the different ingredients selected?***

*A.* Campbell's Strained Baby Soups are planned to provide a balance in nutrients to supplement the daily milk diet. Since it takes many different foods to supply the approximately 40 nutrients needed for infant development and energy, we use vegetables and a cereal in preparing each of the four meat soups. Flavor is improved, too. For instance, liver alone has too strong a taste for some babies, but blended with vegetables, palatability is enhanced. It should also be noted that these soups are intended for use as early in normal infancy as any other strained baby foods.

***Q. What measures are taken to conserve food constituents?***

*A.* In preparing these Baby Soups, Campbell's have developed a method, based on the latest scientific knowledge, which retains the minerals and efficiently conserves the vitamins.

A comprehensive analysis of each soup may be had upon request to Campbell Soup Company, Camden, New Jersey.

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*BEEF*
*LAMB*
*LIVER*
*VEGETABLE*

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'SULFATHALIDINE' *phthalylsulfathiazole* is indicated also in the treatment of regional ileitis, as a supplement to the therapy of amebiasis, giardiasis and paratyphoid infections, and as an adjunct to intestinal surgery.

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1. J.A.M.A. *129*:1080, Dec. 15, 1945
2. Illinois M. J. *88*:85, August, 1945

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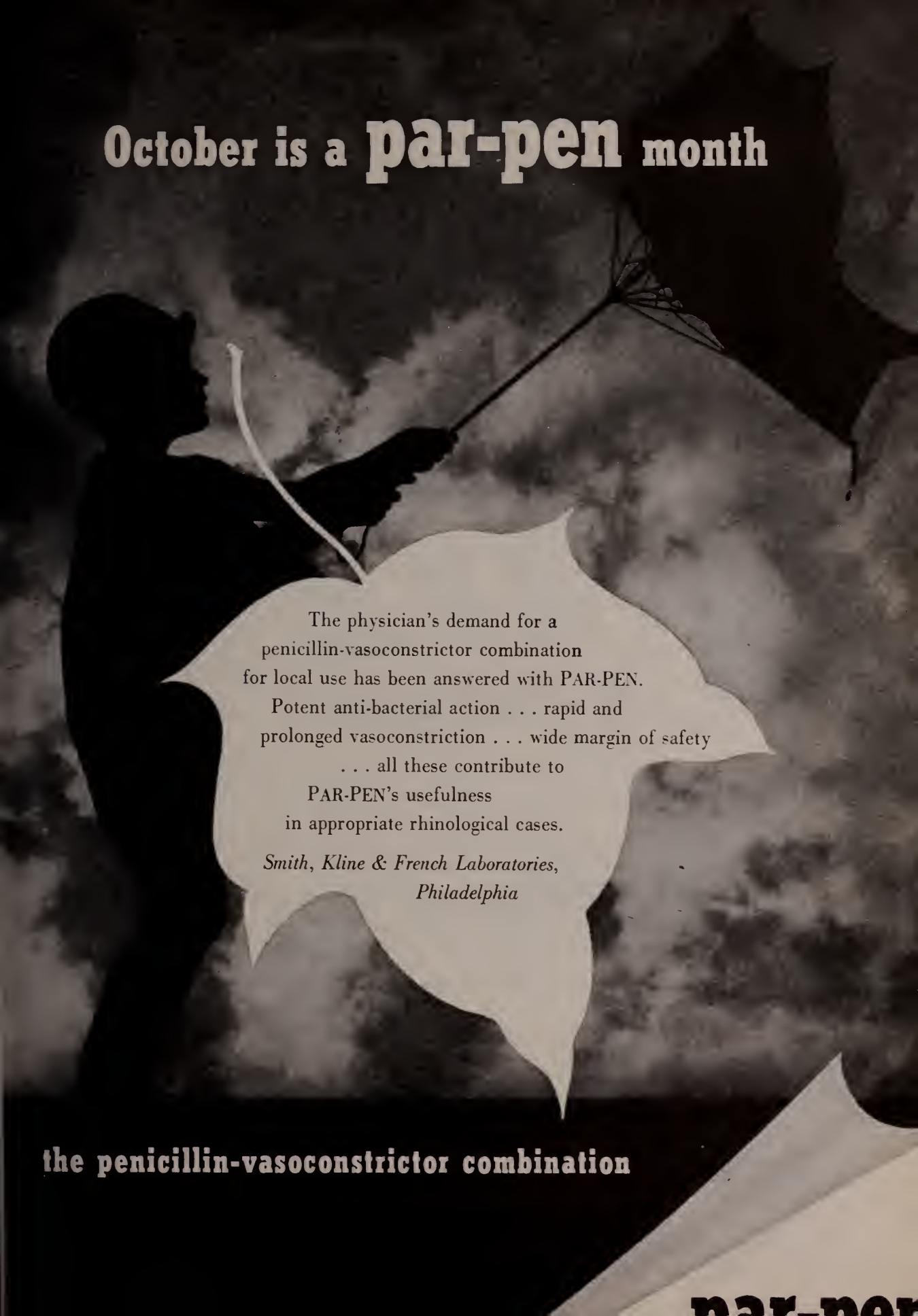
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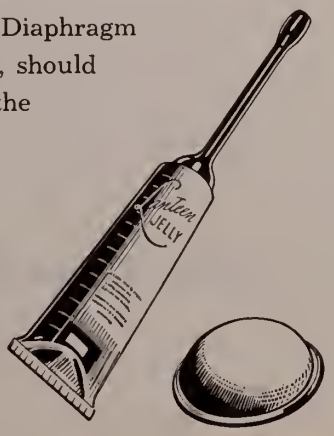
MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

# *Toward a Better World*



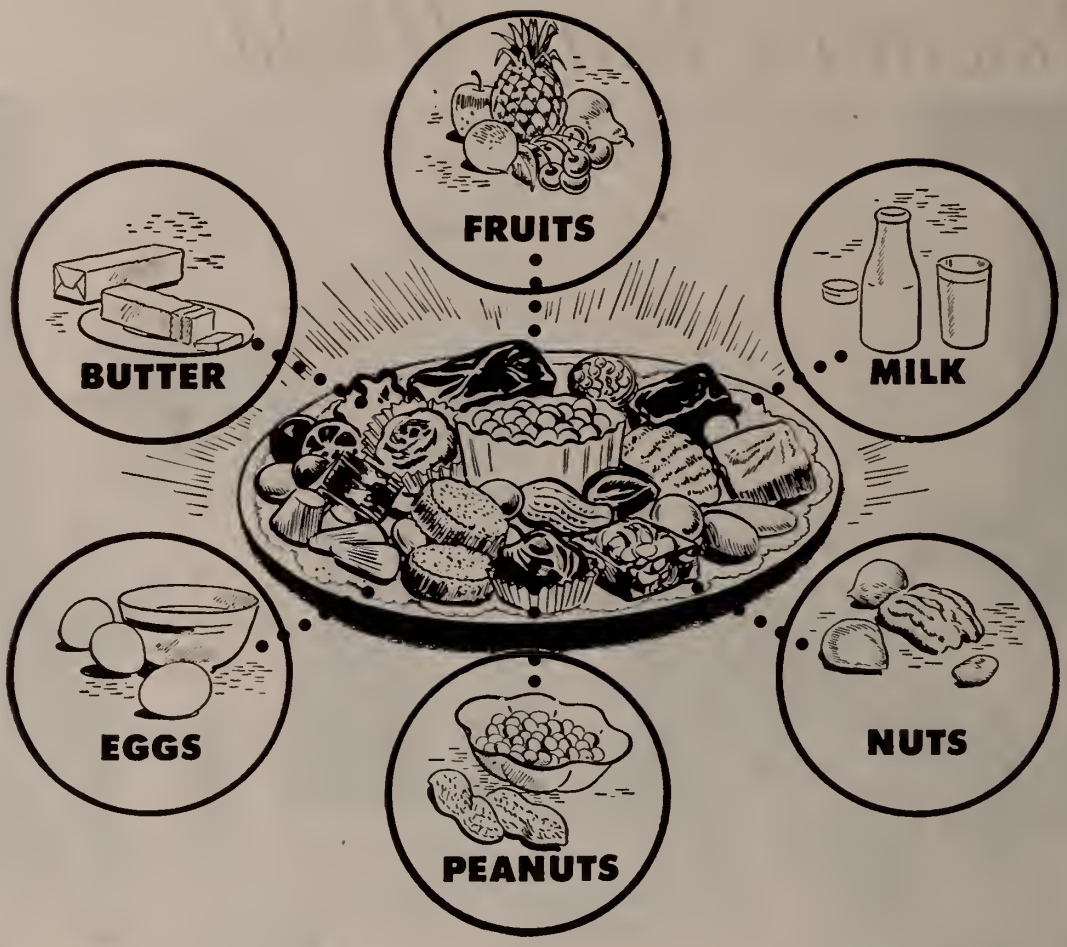

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*Richards, R. K., and Perlstein, M. A. (1945), Tridione, A New Experimental Drug for the Treatment of Convulsive and Related Disorders, Proc. Chicago Neurological Soc., Jan. 9; and (1946), Arch. Neurol. and Psychiatry, 55:164, February.*

*Lennox, W. G. (1945), Petit Mal Epilepsies: Their Treatment with Tridione, J. Amer. Med. Assn., 129:1069, December 15.*

*DeJong, R. N. (1946), Effect of Tridione in the Control of Psychomotor Attacks, J. Amer. Med. Assn., 130:565, March 2.*

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**The Perfect Golf Swing.**

After years of
diligent practice
and pains taking cerebration
I have developed
a perfect golf swing.

It is the opinion
of all students of the game,
in which opinion
I heartily agree,
that my golf swing
is now the acme of
ease, grace, rythm,
relaxation, concentration
and accuracy.
It is the perfection
of muscular coordination,
machine like precision
and mental equilibrium.

In its perfected state
this swing utterly ignores
grip, stance, pivot,
wrist, shift, back swing,
eye-on-the-ball and follow-through.
Yet it is without a flaw.

There is but one requisite
to attain this perfect swing
and that is
that it be directed
at a dandelion.
In the parlance
of golf addicts
it is known as
the practice swing
and with the humble dandelion
as its objective
the stroke is always perfect.

But sadly enough
there is a fly
in the ointment.
When I swing
at a dandelion
the swing is perfection itself.
But when I stand
facing a golf ball
all things become changed.
Muscles become tense,
rythm is lost,
concentration disappears
and cerebration ceases.
The result is unpredictable
but always bad.

What is the answer?
Am I to be defeated thusly
and in said manner?

Not so, young man, not so!

I now have
a golden yellow dandelion
painted on each golf ball.
I no longer swing
at the golf ball.
I swing at the
dandelion.
And the taste
of perfect attainment
is as honey
under the tongue
and par
is but a viper
trampled under foot.

Competitors beware!

**PATHOLOGICAL SONNETS.**

**Coronary Occlusion.**

**Progressively my hypertension rose,**
**But I went blithely on my busy way**
**All unaware of what it might impose**
**Or peril that I face from day to day.**
**And then one night the fateful seizure came.**
**Substernal, agonizing painful throes,**
**My chest was in a vice to crush and main.**
**Impending, instant doom before me rose.**
**With gnawing, piercing, crushing, boring pain**
**I suffered bitter anguish and complained,**
**'Tis true that morphine eased my harrowed brain.**
**But panic, dread and fear of death remained.**
**A long and dreary convalescent track**
**Is filled with dread of when it may come back.**

LOONEY LIMERICK

A traveler crossing the ocean
Became much obsessed with the nocean
That each night about eight
He should long dissert eight
On waves and perpetual mocean.

**Cynical Cinquain**
**Rhymes**

**We write**
**Our nonsense rhymes**
**And down life's pathway walk,**
**We laugh and joke, yet many times**
**We squawk.**




# Peptic Ulcer Dietary

***Gelatine studies have shown the way in peptic ulcer management***

The use of a bland protein for its acid neutralizing properties and supplemental food value is gaining enthusiastic medical support.

*Peptic Ulcer Dietary*, details a proved method for the use of Knox Gelatine in the management of various types of peptic ulcer.

Written in simple language, clearly understandable, we believe your patients will find it a practical guide once you have prescribed.

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2. *Special Ulcer Diet.* Bland, and liberal in calories and protein, many doctors regularly prescribe this diet just as it's given in the Knox Booklet.
3. *Diet for and management of bleeding peptic ulcer.*
4. *Several pages of suitable recipes* that can be made easily and quickly in the home.

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PLAIN, UNFLAVORED GELATINE...ALL PROTEIN, NO SUGAR



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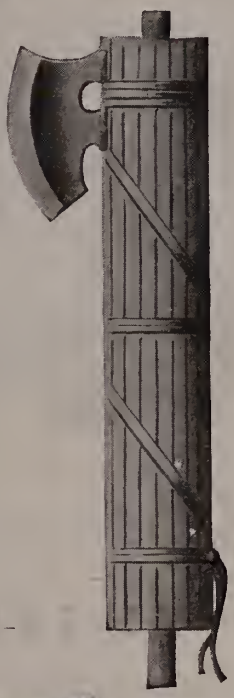
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(Continued on page 60)

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Any doctor of medicine who uses surgery in his practice will find this meeting of great value.
A program will be mailed to every member of the medical profession in good standing in the United States and Canada, upon request to the Secretary, about October 1.

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# Physical Medicine Abstracts

John S. Coulter, M.D.

## LONG RANGE INSURANCE FOR ALL GENERAL HOSPITALS — THE DEPARTMENT OF PHYSICAL MEDICINE

Jessie Wright, M.D., Director, D. T. Watson School of Physical Therapy, University of Pittsburgh School of Medicine

In HOSPITALS, 20;6;52
June 1946

The average general hospital of 50 or more beds may add to its efficiency in caring for patients and decrease operating expenses by establishing a department of physical medicine. Too many hospital administrators and staffs have the mistaken idea that an imposing outlay of expensive equipment is necessary before a department for physical treatment may be planned.

In a small hospital the best initial investment is a registered physical therapist who may start in a small department advantageously located.

The prescription should be specific in limiting time of treatment by designating "daily for six days" or for an outpatient "three times a week for three weeks" or whatever the physician wishes. This plan sets a time for the patient to report to his attending physician unless the physician is seeing him on daily hospital rounds.

An approved department for physical therapy, reconditioning, and occupational therapy needs medical direction by someone who has made a special study of this field and has a keen interest in current advances in diagnostic procedures and treatment. The physician directing the department of physical medicine should be responsible for keeping members of the hospital staff up to date on the prescription for physical therapy. He should be available for consultation on subsequent related reconditioning, occupational and work therapy as needed and adapted to the individual patient for rehabilitation.

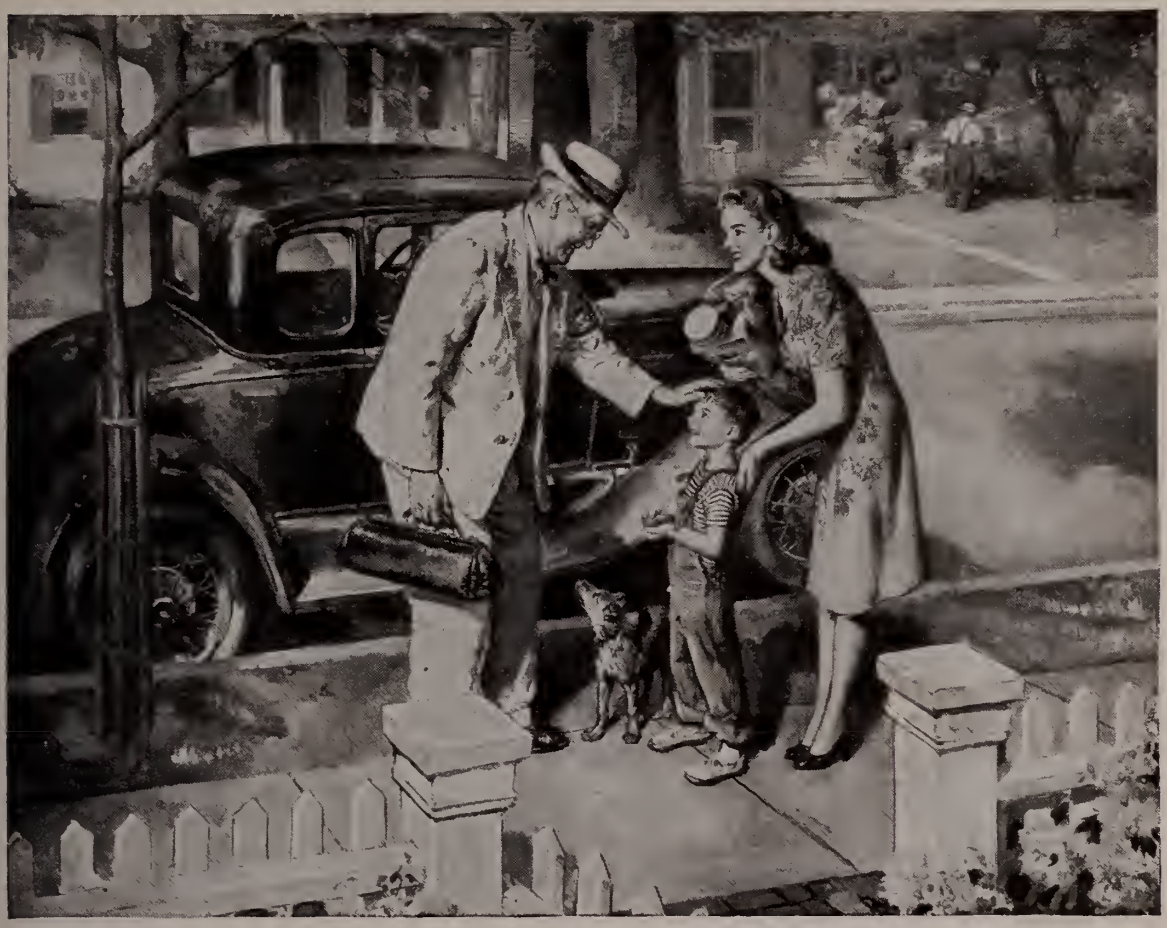
A department of physical medicine will differ in requirements for staff and equipment according to the community the institution serves.

## THERAPY OF PSORIASIS

Current Medical Literature
Ohio State Medical Journal, Columbus
42:217-328 (March) 1946
In JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 131;6;565
June 8, 1946

Schonberg observed 207 cases of psoriasis among 7,000 dermatologic cases in a military hospital. In 35 of the patients the psoriasis was of such severity that hospitalization seemed advisable. Two of the patients had psoriasis guttata, whereas all the others had psoriasis vulgaris. The author gained the impression that the various types of parenteral and enteral medication were of no apparent value in this series of cases. Exacerbations were most prevalent where infiltrated patches remained. Dietary measures were of questionable value. Autohemotherapy seemed to benefit only the acute cases of psoriasis guttata. Genital and intertriginous, nail and scalp lesions were most resistant to therapy. Nail lesions did not respond to any measures. Although there was some evidence of familial tendency in several of the cases, no definite conclusions could be drawn. The best method of therapy is external. A soap suds soak and keratolytic preparations were employed

(*Continued on page 64*)



# The doctor makes his rounds

● Wherever he goes, he is welcome . . . his life is dedicated to serving others.

Not all his calls are associated with illness. He is often friend and counselor . . . he is present when life begins, watches it flourish and develop. His satisfactions in life are reflected in the smiling faces of youngsters like this one above, and of countless others whom he has long attended.

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## PHYSICAL MEDICINE ABSTRACTS
(Continued)

for the first few days of treatment. This was followed by a 5 per cent crude coal tar ointment in conjunction with ultraviolet, as suggested by Goeckerman. Residual lesions were treated with 1 to 3 per cent chrysarobin and ultraviolet. Certain cases of psoriasis will not be influenced by therapy of any kind.

---

## ARTIFICIAL SUNLIGHT TREATMENT IN INDUSTRY

Editorial

In BRITISH MEDICAL JOURNAL, No. 4457;882
June 8, 1946

Artificial sunlight treatment has been hailed as a valuable tonic for industrial and office workers. It is claimed that this treatment lessens the incidence of sickness and accidents, reduces absenteeism, hastens recovery from illness and injury, and increases production. Such claims have encouraged managers in commerce and industry to install solaria for the benefit of their workers. Nevertheless, the more critical members of the medical profession who are able to advise industry have asked for more convincing evidence than that to be found in the published results of previous trials of the effects of collective irradiation of industrial workers and Service personnel.

A large-scale and controlled inquiry, the results of which have now been published, was planned and carried out by Dr. Dora Colebrook under the guidance of a special committee of the Industrial Health Research Board of the Medical Research Council. The object was "to ascertain in a scientifically controlled experiment whether the collective irradiation of workers by ultraviolet light from quartz mercury arc lamps, using a minimum perceptible erythema dose, will reduce their rates of sickness absence and the duration of their colds."

The results of these extensive and carefully controlled trials do not confirm the claim that the commonly accepted technique for the irradiation of factory, mine, and office workers with artificial sunlight is effective in reducing sickness and accident incidence and increasing efficiency. Those chosen for the trials had every opportunity of benefiting from the treatment,

(*Continued on page* 66)

# The Role of Protein as a Pharmacodynamic Agent

The functions of proteins in the maintenance of tissue integrity, in the formation of enzymes and hormones, and in the growth processes are well known. But the uses of protein for purely pharmacodynamic purposes is only beginning to be recognized.

"It is not generally appreciated that in patients with edema without azotemia a high protein diet... may serve a useful function as a diuretic agent."* The factors held responsible for the protein-induced increase in urinary output are an augmented excretion of urea (provided by the protein), an increased elimination of sodium due to the presence of the fixed acid of the protein diet, and the higher potassium content of this diet. Incidentally, another advantage accrues from the high protein intake given for the purpose of diuresis — that of correcting negative nitrogen balance when present.

Among the protein foods of man, meat ranks high, not only because of the generous supply of protein it provides, but also because its protein is biologically complete, applicable for the satisfaction of every protein need. In the high protein diet, it provides unrivaled palatability and taste appeal, as well as endless variety.

*Stare, Fredrick J., and Thorn, George W.: Protein Nutrition in Problems of Medical Interest, J.A.M.A. *127*:1120 (April 28) 1945.

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PHYSICAL MEDICINE (Continued)

because half the clerical workers, many of the factory workers, and all the underground workers at the colliery spent the whole of their working time in artificial light. In none of these communities was the average amount of sickness absence found to be significantly less among those who were exposed only to the screened lamps. In the two communities in which the duration of colds was studied, and in the colliery where injury and total absence were measured, the three treated groups did not differ significantly. Nor did any of the communities show any evidence, in the characteristics measured, of a vitamin D deficiency. A third of the people treated stated that their health had been better during their attendance for treatment, but there was no evidence that this benefit was due to the shorter rays, since the numbers were almost equally distributed in the treated groups. The treated groups in the colliery — i.e., those receiving and those not receiving the shorter ultraviolet rays — had a significant advantage over the untreated controls in respect of sickness and total absence, but it was not possible to select at random the untreated group whose health in the previous year, when there was no sunlight treatment, was found to be less good than that of the treated men. In the office and factory those given no treatment at all showed fewer days with colds than those who were treated. This result probably has no significance, but was due to a greater accuracy in the records of those who attended the clinics.

The results of this investigation "debunk" some of the claims made by manufacturers and doctors for using a particular type of artificial sunlight as a tonic to prevent absence from work, but they provide no evidence as to the value of ultra-violet light for treating particular diseases, other than perhaps the common cold. A negative result such as this may be less satisfactory to the research worker than a positive one, but this inquiry will have been fully justified if it serves to illustrate both the method of and the difficulties inherent in carrying out such a carefully controlled and large-scale trial in an industrial population. Finally, it is hoped that it may succeed in diverting the attention of management and workers from what could at best be hardly more than a placebo to the more radical methods of preventing sickness and absenteeism in industry.


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# Book Reviews

Autopsy Diagnosis and Technic. By Otto Saphir, M.D., Pathologist, Michael Reese Hospital; Professor of Pathology, University of Illinois Medical School, Chicago. Second Edition, revised and enlarged. Paul B. Hoeber, Inc. New York. 1946.

The immortal Osler has stated: "As is our pathology, so is our practice", a statement that carries greater and greater conviction as medical science grows in complexity. The autopsy table furnishes the most complete means of comparing clinical findings with actual tissue changes, but such opportunities there afforded can be most completely realized when the services of a trained pathologist are available. Obviously this condition can never be realized, and much valuable knowledge and information are never brought to the attention of the practitioner who feels that for one cause or another he should not perform post-mortem examinations on his cases. One commonly expressed reason for this unfortunate state of affairs is lack of knowledge of the technic of post-mortem examinations and a feeling of uncertainty as to the proper method of demonstrating lesions and securing tissue for histological study. For these reasons if for no others, Dr. Saphir's book should appeal to the doctor who may wish to perform an occasional autopsy. He can refresh his memory as to the general technical considerations, find out what to look for and where, as well as how to examine areas not usually investigated, such as the neck organs or the skeletal and muscle system.

To the trained pathologist such details are merely a matter of course, but to him this book should be a handy reference. Some data such as the chapter on weights and measurements of organs has been taken from original sources and has been enlarged. The tables of differential diagnostic features of lesions of various organs are clear and save much time. The section on pathologic changes in the breast has been entirely rewritten and expanded since it is also intended for the use of the physician in general practice. The discussion of accidental death merits special consideration. The pathologic findings of the neonatal period including stillborn infants are considered in a special chapter but reference is made throughout the text to conditions peculiar to infancy and childhood. A

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## BOOK REVIEWS (Continued)

new chapter on the anatomic findings of vitamin deficiencies should stimulate further search for these findings for better coordination with the clinical reports. Another chapter or certain tropical diseases is particularly pertinent at this time. A very brief discussion on facilitating the undertaker's work might well be given more emphasis; the mortician frequently is the discouraging factor in securing autopsies.

The text is clarified with sixty-nine line drawings and eighteen tables. There is no tendency to usurp the functions of texts on pathology. There is no formal bibliography but sources of material are acknowledged in foot-notes. There is a workable index. The format is of the handbook type; the printing is clear and on dull finished paper. The book slips easily into one's coat pocket. Certainly Dr. Saphir is to be commended for presenting so handy and valuable a compendium to the profession.

J.C.M.

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SKIN DISEASES IN CHILDREN. Second Edition revised and enlarged. By George M. MacKee, M.D., Professor of Clinical Dermotolgy and Syphilology New York Post Graduate Medical School, Columbia University, New York; and Antony C. Cipollaro, M.D., Associate in Dermatology and Syphilology, New York Post Graduate Medical School, Columbia University, New York. With contributed Chapters. Paul B. Hoeber, Inc., New York. 1946. 448 pages, illustrated.

This book, although written for the general practitioner will be welcomed and appreciated by all who handle children, since many cutaneous affections are seen only in infancy and childhood, a few are peculiar to adolescence, and in many instances juvenile manifestations are different from those found in the adult. Any one who is familiar with the first edition of this work which was published in 1936 will be more than satisfied with the second edition, which, while retaining all the simplicity and practical features of the first edition, brings the material quite up to date. The illustrations are clear and not confused with useless detail; it is regrettable that the four color photographs on the frontispiece were not reproduced on a larger scale. Descriptions of lesions are brief and concise. Standard terminology is strictly adhered to. Recommendations as to treatment show a conservative trend and clearly reflect extensive personal experience, but are not restricted thereto as each chapter is supported by a fairly extensive bibliography. The value of the book is greatly enhanced by the inclusion of four contributed chapters: Allergic Dermatoses by Frances Pascher, M.D., should be of real interest to every pediatrician. Congenital Cutaneous Anomalies by Eugene F. Traub, M.D., is an excellent discussion of this important field. Contagious Diseases by Nathan Sobel, a new inclusion, seems to go somewhat further afield into the realm of general medical diagnosis and care

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## BOOK REVIEWS (Continued)

than might reasonably be expected in a treatise on skin diseases, and is entirely devoid of any illustrations. Syphilis in Children by Terman Beerman is an excellent up-to-date monograph of the subject.

The book is set in Linotype Fairfield with a new format which makes it easy to read. It is recommended for inclusion in the practitioner's library.

J.C.M.

## Books Received

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

HIPPOCRATIC WISDOM; For Him Who Wishes to Pursue Properly the Science of Medicine. A Modern Appreciation of Ancient Scientific Achievement; By William F. Petersen, M.D., Chicago. Charles C. Thomas, Publisher, Springfield, Illinois. Price $7.50.

VOCATIONAL AND PROFESSIONAL MONOGRAPHS: PHYSIOTHERAPY; By Thomas Francis Hennessey, M.D., Dean and Director, Massachusetts School of Physiotherapy, Boston, Massachusetts. Bellman Publishing Company, Ind., Boston, Massachusetts. Price $0.75.


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PERIPHERAL VASCULAR DISEASES: By Edgar V. Allen, B.S., M.A., M.D., M.S., in Medicine, F.A.C.P., Division of Medicine, Mayo Clinic, Associate Professor of Medicine, Mayo Foundation, Graduate School, University of Minnesota; Diplomate of the American Board of Internal Medicine; and Nelson W. Barker, B.A., M.D., M.S., in Medicine, F.A.C.P., Division of Medicine, Mayo Clinic, Associate Professor Medicine, Mayo Foundation, Graduate School, University of Minnesota; Diplomate of the American Board of Internal Medicine; and Edgar A. Hines, Jr., M.D., B.S., M.A., M. S., in Medicine, Mayo Foundation, Graduate School, University of Minnesota; with Associates in the Mayo Clinic and Mayo Foundation. 871 pages, with 386 illustrations, 7 in color. Philadelphia and London: W. B. Saunders Company, 1946. Price $10.00.

DIABETIC CARE IN PICTURES: Simplified Statements with Illustrations Prepared for the Use of the Patient; By Helen Rosenthal, B.S., Associate Dietitian in the Food Clinic, the Boston Dispensary; Assistant in Medicine, Tufts College Medical School; Frances Stern, M.A., (Honorary) Chief of the Food Clinic, The Boston Dispensary; Instructor of Medicine, Tufts College Medical and Dental Schools and Joseph Rosenthal, M.D., Chief of Diabetic Clinic, Assistant Medical Director, Medical

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## BOOKS RECEIVED (Continued)

Supervisor of the Domiciliary Medical Service, The Boston Dispensary; Asst. Professor of Medicine, Tufts College Medical School. With 137 original Illustrations, including 4 in color. Prepared under the Direction of the Authors. Philadelphia and London: J. B. Lippincott Company, 1946. Price $2.00.

OPHTHALMOLOGY IN THE WAR YEARS: Edited by Meyer Wiener, M.D., Professor of Clinical Ophthalmology, Washington University School of Medicine; Honorary Consultant in Ophthalmology, Bureau of Medicine and Surgery, United States Navy. Volume I (1940-1943). The Year Book Publishers, Inc., Chicago, 1946. Price $13.50.

MODERN DRUG ENCYCLOPEDIA and Therapeutic Index. Edited by Alexander B. Gutman, Ph.D., M.D., F.A.C.P., Assistant Professor of Medicine, College of Physicians and Surgeons, Columbia University, New York, N. Y., Associate Attending Physician, Presbyterian Hospital, New York, N. Y., Associate Attending Physician, Vanderbilt Clinic, New York, N. Y., Third Edition. The Yorke Publishing Company, Inc., New York, 1946.

SINGIN' YANKEES: By Philip D. Jordan, 1946. The University of Minnesota Press, Minneapolis. Price $3.50.

## STREPTOMYCIN CURES NEGRO SUFFERING FROM TULAREMIC PNEUMONIA

Two Brooklyn physicians, Richard B. Cohen and Richard Lasser, report in the August 3 issue of *The Journal of the American Medical Association* that the new antibiotic drug streptomycin cured a 33 year old Negro patient suffering from primary tularemic pneumonia, which is usually fatal in from 30 to 60 per cent of the cases.

The two doctors say that when the seriously ill patient was first brought to the hospital, it was thought that he was suffering from primary atypical pnemonia. He was given large doses of penicillin and sulfadiazine, but his condition failed to improve. Then, after careful questioning of the family it was learned that the man had gone rabbit hunting just prior to his illness.

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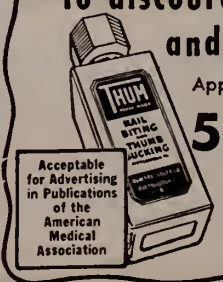
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Drs. Cohen and Lasser cited one investigator who reported 21 cases of tularemia complicated with pneumonia, "of which eight cases were comparable with ours. Of these eight, six were fatal."

## QUESTION USEFULNESS OF QUARANTINE AGAINST POLIOMYELITIS

Usefulness of quarantines established by some states to prevent the spread of poliomyelitis is held "highly questionable" by *The Journal of the American Medical Association.* In the July 27 issue, *The Journal* says in an editorial:

"This year, as in previous years, some sections of the country have developed an exceptionally high incidence of poliomyelitis. A few cities in southern Florida were involved in this manner. One of the neighboring states considered the establishment of a quarantine against Florida residents. Georgia actually imposed such a quarantine against all persons coming from the former state, even including Pensacola, which is 402 miles from the nearest city in which there has been an outbreak of poliomyelitis that could possibly be considered as epidemic in nature. The usefulness of this interstate quarantine is highly questionable. The overwhelming consensus of authorities in epidemiology and public health is that such interstate quarantine does not serve any useful purpose in preventing the spread of poliomyelitis. In the absence of more specific knowledge on the methods of spread of the poliomyelitis virus than is now available, state quarantine can only be considered reminiscent of the old practice of shot-gun quarantine against yellow fever before learning the role of the yellow fever bearing mosquito."

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## TWENTY-FIFTH ANNIVERSITY OF THE DISCOVERY OF INSULIN

The twenty-fifth anniversary of the discovery of Insulin was observed with a program in Convocation Hall, at the University of Toronto, on September 16. Many Internationally known figures in the field of medicine were present to honor the occasion. Among them were R. D. Lawrence, physician in charge, Diabetic Clinic, Kings College Hospital, London, England; H.C. Hagedorn, of Gentofte, Denmark: Bernado A. Houssay, Research Institute of Experimental Biology and Medicine, Buenos Aires, Argentina: and Elliott P. Joslin, Harvard Medical School, Boston, U.S.A. This was followed by the regular annual meeting of the American Diabetes Association.

On September 23 Eli Lilly and Company sponsored an International diabetes clinic at the Indiana University Medical Center in Herty Hall of the State Board of Health Building. Indianapolis, Indiana. International importance was given to this meeting by the presence of Professor Charles H. Best, Toronto, Canada, co-discoverer with Banting of Insulin, Professor Houssay, Dr. Lawrence, and Dr. Hagedorn. They discussed various phases of diabetic care.

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Health is not an inalienable right. It is a privilege. Privileges invariably entail equivalent responsibilities. It is so easy to accept privileges that before long mankind takes them for granted and claims them for inherent rights. Nature grants few rights, preferring to demand that privileges be earned. Health, like freedom and peace, continues only as we exert ourselves wisely to maintain it. Edward J. Stieglitz, M.D., A Future for Preventive Medicine.



**In *Cheilitis* from LIPSTICK**

**Intractable exfoliative lip dermatoses may often be traced to eosin lipstick dyes. Remove the offending irritants, and the symptoms often disappear. In lipstick hypersensitivity, prescribe AR-EX NON-PERMANENT LIPSTICK—so cosmetically desirable, yet free from all known irritants. *Send for Free Formulary.***

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# a Poor Scholar . . . because of a Poor Breakfast

MANY a child is scolded for dullness when he should be treated for undernourishment. In hundreds of homes a "continental" breakfast of a roll and coffee is the rule. If, day after day, a child breaks the night's fast of twelve hours on this scant fare, — or less — small wonder that he is listless, nervous, or stupid at school.

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Pablum (Mead's Cereal thoroughly cooked) is a palatable cereal enriched with vitamin- and mineral-containing foods, consisting of wheatmeal, oatmeal, wheat embryo, cornmeal, beef bone, alfalfa leaf, brewers' yeast, sodium chloride and reduced iron. (The oatmeal form of Pablum is called Pabena.)
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"TOMMY, that's the third time this week you haven't learned your lesson. W h y don't you listen to me when I tell you how to work the problems?"

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# The ILLINOIS Medical Journal

VOL. 90 NO. 4

October, 1946

In This Issue

## The Management of Persistent Occiput Posterior

## Indications for Antibiotics (Penicillin and Streptomycin) in Urinary Tract Infections

## Vocational Rehabilitation in Illinois

(See page 41 for complete table of contents)

OFFICIAL JOURNAL OF THE ILLINOIS STATE MEDICAL SOCIETY

## at what pH

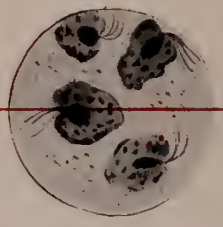
## do vaginal organisms

## thrive ?



pH 3.8 to 4.4

NORMAL PROTECTIVE DÖDERLEIN BACILLUS



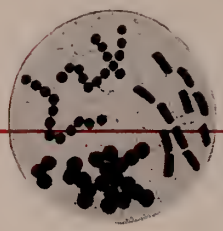
pH 5 to 6

TRICHOMONAS VAGINALIS



pH 5.5 to 6.8

MONILIA ALBICANS



pH 5.8 to 7.8

STREPTOCOCCUS, STAPHYLOCOCCUS, ESCHERICHIA COLI



pH 6.8 to 8.5

GONOCOCCUS

The Floraquin treatment of vaginal leukorrhea accomplishes rehabilitation of the vaginal mucosa.

Since the common vaginal pathogens require a pH of 5.0 or above, and the favorable pH for the protective Döderlein bacillus is below 5.0, Floraquin is acidulated to produce an average vaginal pH of 4.0 to 4.4.

Floraquin contains the nontoxic protozoacide, Diodoquin, which effectively destroys Trichomonas vaginalis.

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Floraquin and Diodoquin are the registered trademarks of G. D. Searle & Co., Chicago 80, Illinois.

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| Vitamin A | 10,000 U.S.P. units |
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| Riboflavin | 3 mg. |
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# ...names DESIGNED FOR YOUR CONVENIENCE

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*Harvesting influenza virus from chick extraembryonic fluids*

# Now It Can Be Told

● The prevalence of Influenza during World War I stimulated increased research for better immunizing agents to control this dread disease.

Since 1933 when Smith, Andrewes and Laidlaw isolated a filtrable virus from patients ill with clinical influenza and established the viral etiology of the disease, numerous attempts to develop a prophylactic vaccine have been made.

Burnet, Henle, and Nigg obtained a high concentration of virus in chick extraembryonic fluids; and vaccines made from such fluids were subsequently studied by a large number of investigators. Some degree of efficacy of these vaccine preparations was shown both by antibody response and by protection against experimental infection of test animals and of human beings.

Although for security reasons the fact was not revealed during the war, the Pitman-Moore Laboratories are now proud to list such a vaccine among the prophylactic and therapeutic medicines of which it supplied large quantities to the armed forces.

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**Sulfonamides**
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# A Specific Type of PRECORDIAL DISTRESS

"The cardiac symptoms of the male climacterium represent a specific type of precordial distress for which gonadal-hormone therapy is the most satisfactory treatment."[1]

ORETON, testosterone propionate, usually effects a decrease in the frequency, severity and duration of attacks of the form of angina pectoris caused by male sex hormone deficiency.

# ORETON

ORETON (testosterone propionate) is administered by intramuscular injection in doses of 25 mg. two to three times weekly for six to eight weeks. After improvement, the frequency and dose are reduced and, often, freedom from further pain can be maintained with ORETON-M Tablets, 10 mg. administered one to three times daily.

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1. McGavack, T. H.: J. Clin. Endocrinol. 3:71, 1943.

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# EFFECTIVES . . .
## but not cure-alls

**M**odern therapeutics support the premise that no single medication will successfully combat all ear conditions. For that reason . . . DOHO, specialists in the development of effective ear medications . . . offer

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**IN ACUTE OTITIS MEDIA**

When pain, fever, edema, leucocytosis, sense of fullness and impaired hearing are present—AURALGAN by its potent decongestant, dehydrating and analgesic action provides effective relief of pain and inflammation.

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O-TOS-MO-SAN provides a new Sulfa combination of Sulfathiazole and Urea in Auralgan Glycerol (DOHO) base, completely water-free and having the highest specific gravity obtainable — scientifically developed.

O-TOS-MO-SAN exerts a powerful solvent action on protein matter . . . liquefies and dissolves exuberant granulation tissue . . . cleanses and deodorizes the site of infection . . . and tends to exhilarate normal tissue healing in the effective control of chronic suppurative Otitis Media. Excellent results have also been obtained in furunculosis of the external ear canal.

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Where there is an intact ear drum, neither Sulfonamides nor Urea are effective . . . and under these conditions AURALGAN is indicated.

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FOR HYPOCHROMIC ANEMIAS

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**STABILIZED TO STAY AGREEABLE**

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STEARNS FERROUS GLUCONATE

**FERGON,** by its chemical nature, is inherently agreeable iron. Only slightly ionized, free of precipitating action on proteins,[1] ferrous gluconate is non-astringent, non-irritating, essentially free from gastro-intestinal distress.

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**AVERAGE DOSE** for adults is three to six 5 gr. tablets or four to eight teaspoonfuls of elixir daily; for children, one to four 2½ gr. tablets or one to four teaspoonfuls of elixir daily.

*Supplied* as 0.325 Gm. (5 gr.) tablets, bottles of 100, 500 and 1000; 0.163 Gm. (2½ gr.) tablets, bottles of 100; 5% elixir, bottles of 6 and 16 fl. oz.

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Windsor, Ontario Sydney, Australia Auckland, New Zealand

1. Reznikoff and Goebel: J. Clin. Investigation 16:547, 1937.
2. Editorial: J.A.M.A. 127:1056, 1945.
3. Thompsett: Biochem. J. 34:959, 1940.

## which antibiotic for intranasal therapy?

**Tyrothricin,** the antibacterial component of 'Prothricin' Antibiotic Nasal Decongestant, offers many advantages over penicillin in the topical treatment of sinusitis, rhinitis, coryza, and nasal congestion.

***Tyrothricin** acts swiftly to destroy bacteria when applied locally. Antibacterial effects of penicillin are not marked until two hours after topical application.

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***Tyrothricin** has low surface tension and detergent qualities which promote intimate contact with infected areas and penetration of minute tissue crevices. Penicillin does not.

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**'Prothricin'** Antibiotic Nasal Decongestant contains tyrothricin (0.02%) and 'Propadrine' hydrochloride (1.50%), an effective vasoconstrictor notably free from the undesirable side-effects of ephedrine and its analogs.

**'Prothricin'** decongestant serves to re-establish normal intranasal function and drainage, combats local bacterial infection, and does not impair ciliary activity or other physiologic intranasal processes.

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'PROTHRICIN'

*antibiotic nasal decongestant*

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**Bacterial Vaccine and Bacterial Antigen Combined.**
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THE frequent co-existence of hypochromic anemia and multiple nutritional deficiencies has greatly changed the therapeutic approach to the anemia syndrome. In many instances, measures directed solely at raising the hemoglobin level prove totally inadequate. For speedy recovery, and eradication of the many derangements usually associated with secondary anemia, more than iron alone is frequently required.

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| Vitamin $B_1$ (Thiamine Hydrochloride) | 2 mg. |
| Vitamin $B_2$ (Riboflavin) | 2 mg. |
| Vitamin $B_6$ (Pyridoxine Hydrochloride) | 0.1 mg. |
| Calcium Pantothenate | 0.333 mg. |
| Niacinamide | 10 mg. |

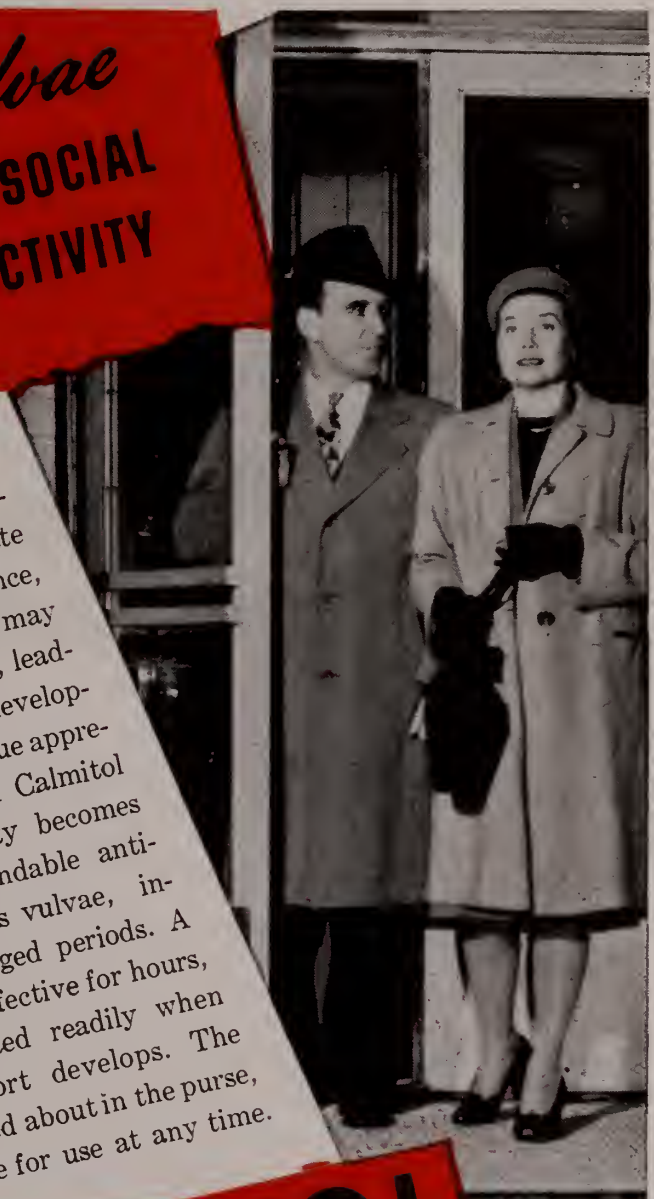
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THE DEPENDABLE ANTI-PRURITIC

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## in the male climacteric

Clinical studies have repeatedly confirmed that the male climacteric is "a definite clinical entity, and once the diagnosis is accurately established, the specific treatment with . . . testosterone yields, in most cases, astonishing results."[1] Neo-Hombreol is preferred by many physicians for the treatment of the male climacteric, for it is the Roche-Organon brand of testosterone propionate which is "effective in relieving the symptoms and in the production of a sense of well-being in the patients."[2] Neo-Hombreol ampuls, 5, 10, and 25 mg, are available in boxes of 3, 6, and 50. For oral androgen therapy, Neo-Hombreol (M) tablets, the Roche-Organon brand of methyl testosterone, are available in boxes of 15, 30, and 100 tablets, 10 mg each.

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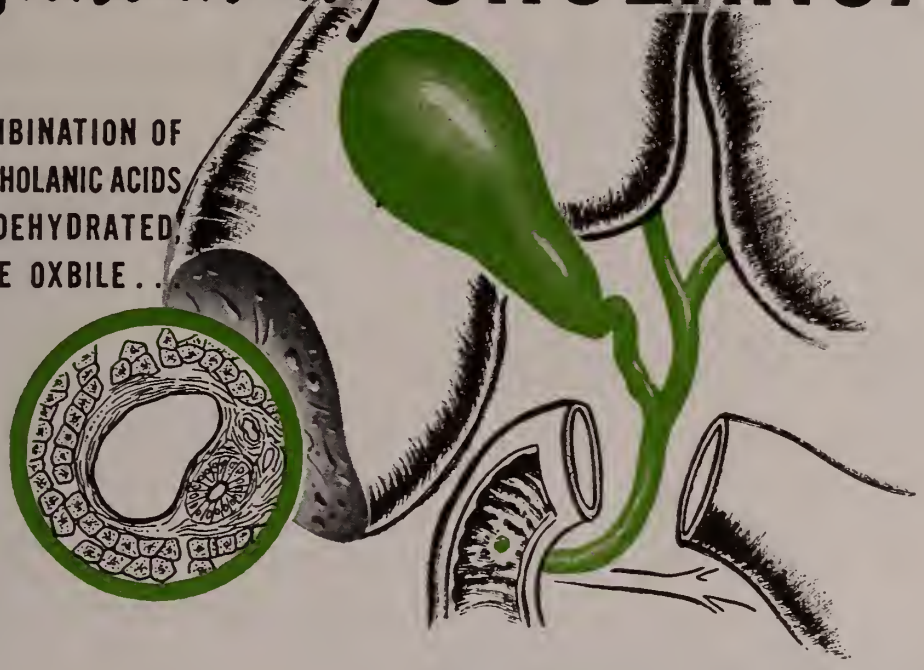
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[1] A. M. Crance, *New York State J. Med.*, 45:2295, 1945
[2] A. A. Werner, *J.A.M.A.*, 127:705, 1945.

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A COMBINATION OF KETOCHOLANIC ACIDS AND DEHYDRATED WHOLE OXBILE . .



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**HYDROCHOLERESIS** A mixture of ketocholanic acids (approximately 90% dehydrocholic acid) to combat biliary stasis by increased production of free flowing bile.

**BILE SALT REPLACEMENT** Dehydrated bile for the efficient digestion of fats, absorption of vitamins and minerals and to stimulate intestinal motility.

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*Complete literature on request.*

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FOR BETTER MEDICAL MANAGEMENT OF BILIARY DISEASE

# *The only vasoconstrictor-sulfonamide which contains Micraform*

Micraform sulfathiazole crystals are extremely minute—approximately 1/1000 the mass of ordinary crystals.

Because Paredrine-Sulfathiazole Suspension contains these minute Micraform crystals, it does not cake or clump, and does not inhibit normal ciliary action. (See the clinical drawings on the opposite page.)

Moreover, when ciliary action is impaired by infection, the Suspension's Micraform sulfathiazole spreads in a fine, even film over the affected mucosa, where it establishes bacteriostasis which often lasts for hours.

*Rhinitis . . . Sinusitis . . . Nasopharyngitis . . . Pharyngitis*

## *Paredrine-Sulfathiazole Suspension*

*Vasoconstriction in minutes . . . Bacteriostasis for hours*

*No ciliary inhibition . . .*

*No caking . . . No clumping*

# *sulfathiazole*



● Five minutes after instillation of Paredrine-Sulfathiazole Suspension in a convalescent nose, the cilia are already forming streams of Micraform sulfathiazole.



● 35 minutes later, the cilia have swept almost all the sulfathiazole away. There is no caking or clumping on *ciliated* epithelium. A few crystals, dried by inspired air, still adhere to the *non-ciliated* anterior borders of the turbinates and to the vibrissae.

***Smith, Kline & French Laboratories***

*Philadelphia, Pa.*



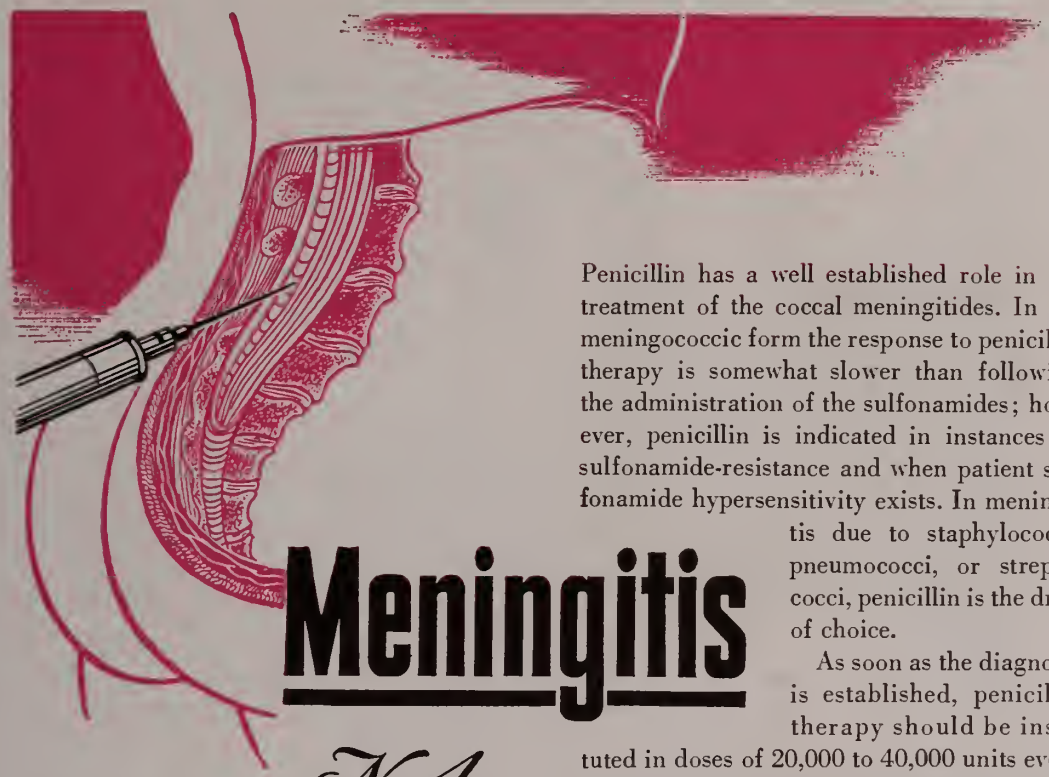
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Preoperative nervousness is multiplied by a sleepless night. Realizing this, many careful surgeons routinely prescribe Nembutal, 1½ grs., the evening before, in addition to the one or two 1½-gr. capsules commonly ordered about an hour before surgery. These men know that the patient prepared in this way arrives in the operating room with fear and nervousness largely allayed, permitting smoother induction of anesthesia and quieter operating procedure. They know the marked *clinical safety* of Nembutal, a feature due partly to the brief action of the drug, which permits rapid recovery, and partly to a dosage only about one-half that of most barbiturates, which greatly reduces the amount of drug to be eliminated. Do you and your surgical patients now enjoy these advantages? If not, your prescription or hospital pharmacy will be happy to cooperate in making them available . . . TODAY.

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# Meningitis

*No. 4*

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### BEFORE YOU DECIDE ON THE PENICILLIN OF YOUR CHOICE

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**SCHENLEY PENICILLIN PRODUCTS**

Penicillin Ophthalmic Ointment Schenley
Penicillin Ointment Schenley
Penicillin Tablets Schenley • Penicillin Schenley

Penicillin has a well established role in the treatment of the coccal meningitides. In the meningococcic form the response to penicillin therapy is somewhat slower than following the administration of the sulfonamides; however, penicillin is indicated in instances of sulfonamide-resistance and when patient sulfonamide hypersensitivity exists. In meningitis due to staphylococci, pneumococci, or streptococci, penicillin is the drug of choice.

As soon as the diagnosis is established, penicillin therapy should be instituted in doses of 20,000 to 40,000 units every two to three hours by the intramuscular route. Treatment should be thorough, and should be continued until all signs and symptoms of the infection have been absent for seven to ten days. Since penicillin administered systemically does not penetrate the subarachnoid space, intrathecal (intraspinal, intracisternal, intraventricular) administration is also required. Ten thousand units in 10 cc. of isotonic solution of sodium chloride should be injected (after withdrawal of an equal volume of fluid) once or twice daily until the spinal fluid is clear, and for four days thereafter.

When concurrent sulfonamides are indicated, they should be administered in a dosage sufficient to establish a blood level of 15 mg. per cent.

Surgical, supportive, and other measures should be employed when indicated.

---

**SPINK, W. W., *and* HALL, W. H.:** *Penicillin Therapy at the University of Minnesota Hospitals: 1942-1944, Ann. Int. Med. 22:510 (April) 1945.*

**WHITE, W. L.; MURPHY, F. D.; LOCKWOOD, J. S., *and* FLIPPIN, H. F.:** *Penicillin in the Treatment of Pneumococcal, Meningococcal, Streptococcal, and Staphylococcal Meningitis, Am. J. Med. Sc. 210:1 (July) 1945.*

**SCHENLEY LABORATORIES, INC.** Executive Offices: 350 Fifth Avenue, New York City



***a troublesome symptom . . .***




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"All patients with peptic ulcer eventually develop constipation."[1] Low residue diet, inactivity and worry are responsible. But the troublesome symptom can be controlled by development of "habit time" and administration of emulsified mineral oil.

AMPHOJEL*, the standard antacid for the management of peptic ulcer, is also supplied with emulsified mineral oil as a convenient dosage form for ulcer patients with a tendency to constipation.

1. PAUL, W. D., and C. RHOMBERG, J. Iowa State M. A. *35*:167 (May) 1945.

*REG. U. S. PAT. OFF.

Bottles of 12 fl. oz.

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**WITH MINERAL OIL**

Wyeth

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USP XII

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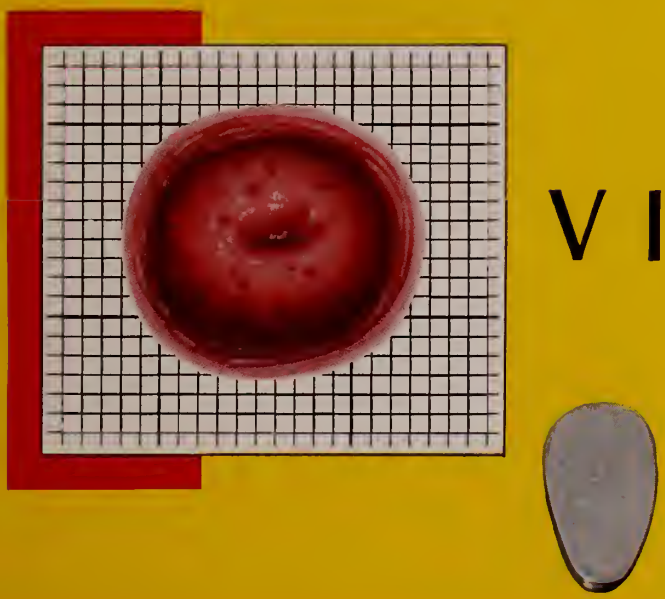
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Privine—Trade Mark Reg. U. S. Pat. Off. and Canada (Brand of Naphazoline hydrochloride)

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***Children***
***actually***
***like to take***

# *Eskadiazine*

***S.K.F.'s***
***new,***
***outstandingly***
***palatable***
**fluid**
***sulfadiazine for oral use***

Eskadiazine—a new *fluid* sulfadiazine for oral use—is so palatable that children actually like to take it. Parents, too, are grateful to be relieved of the chore of crushing tablets and coaxing a sick child to swallow an unappealing mixture.

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*Flippin, H. F., et al.: Am. J. M. Sc. 210:141-147, 1945.

Smith, Kline & French Laboratories, *Philadelphia, Pa.*

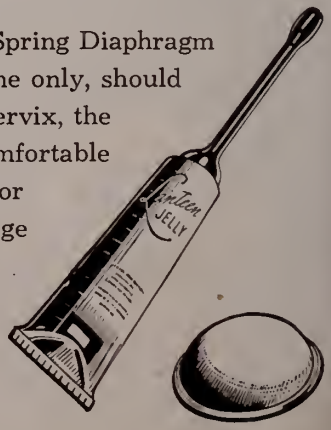
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# • STREPTOMYCIN

## released for clinical use

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Streptomycin Merck is an antibacterial agent of high potency and relatively low toxicity. It is of established value in the following infections:

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**All Infections Caused by**
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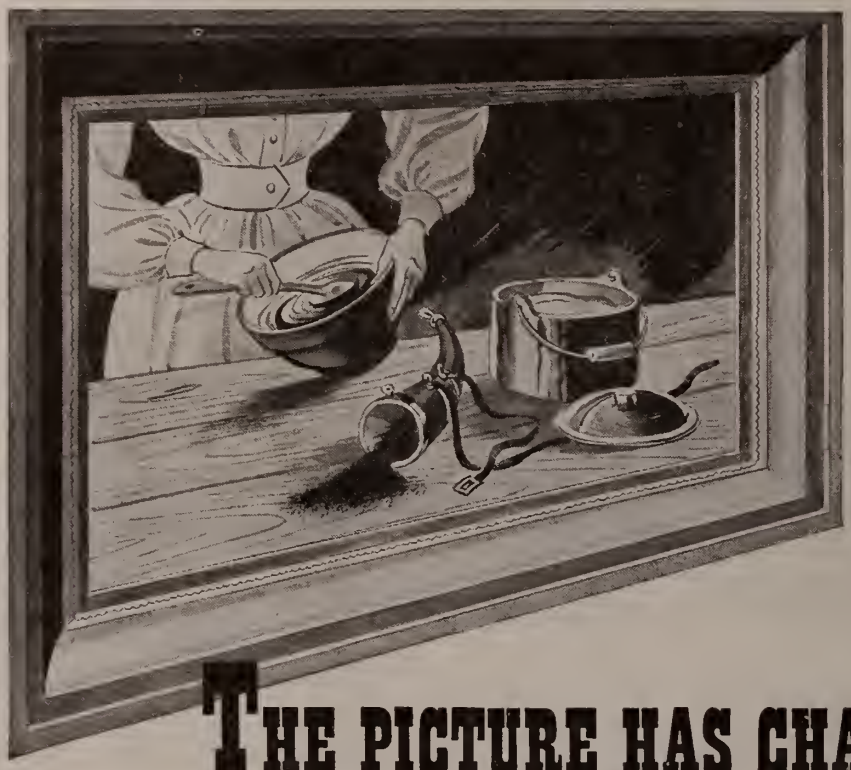
**Urinary Tract infections, Bacteremia, or Meningitis caused by any of the following:**

| | |
|---|---|
| *Esch. coli* | *B. pyocyaneus* |
| *B. proteus* | *B. lactis aerogenes* |
| *Friedlander's bacillus* | *H. influenzae* |

Streptomycin also is a helpful agent in the treatment of certain other diseases caused by susceptible organisms, but its position has not yet been clearly defined.

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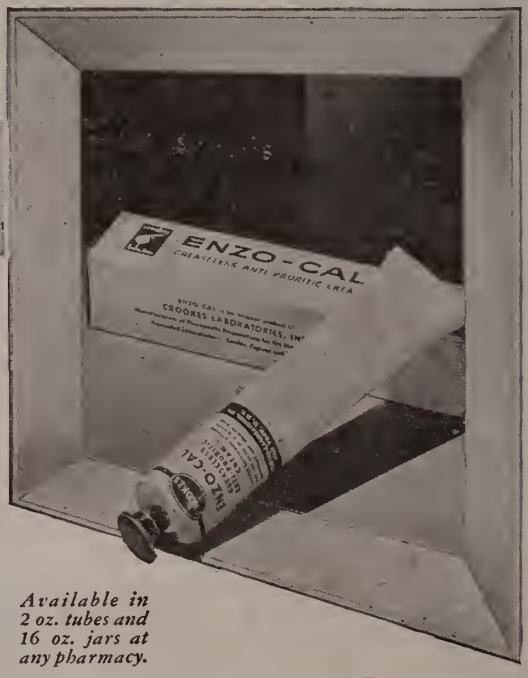
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*J.A.M.A. May 4, 1946

# ANSWER:

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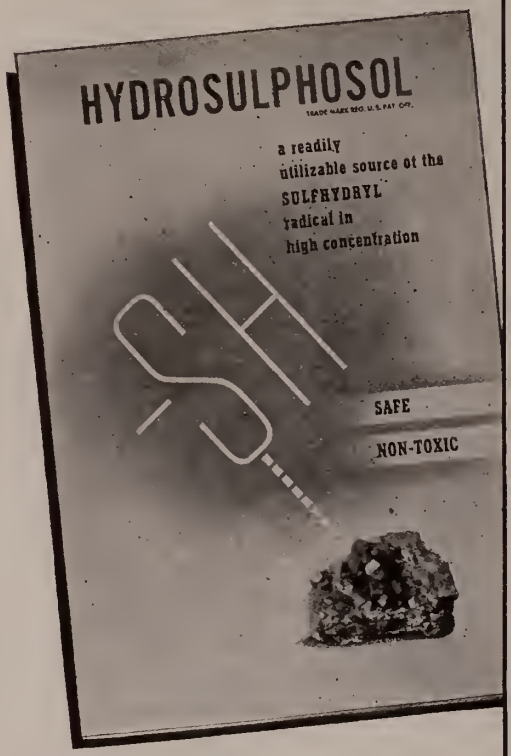
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# HYDROSULPHOSOL

## opens a new chapter in Sulfur Therapy

Dramatic results confirm its value in burns, arthritis, and many conditions in which sulfur imbalance is a clinical factor.




Recommended uses as a home or adjunctive hospital treatment in arthritis—

**FOOT BATH:** Add one ounce of Hydrosulphosol Solution to a large galvanized bucket or container ample in size to immerse both feet and ankles. The water should be about 100 deg. F. at first or a temperature that can be comfortably tolerated. The temperature of such a bath can be gradually raised to 105 deg. F. if this heat can be tolerated. This type bath can be employed also for the arms. Length of bath 20 to 40 minutes.

**TUB BATH:** Add two ounces of Hydrosulphosol Solution to a full tub of water at 100 to 102 deg. F. for five to twenty minutes with a patient moving all of his affected joints while submerged in the bath. An authority on this type of therapy points out the hot bath is useful in subacute or chronic generalized rheumatoid arthritis, although some arthritic patients, particularly those who are emaciated and weakened, do not tolerate exposure to heat and are easily exhausted from prolonged hot baths. In such cases the foot bath would be better indicated.

Fluids should be given freely after the bath (or during the bath if marked sweating occurs). If there is excessive perspiration, 2 to 6 tablets of sodium chloride (1 Gm. each) may be given. All patients should rest in bed for at least an hour after the bath.

**ORAL:** 10 to 15 drops of Hydrosulphosol Solution to a glass of water at least three time a day. If initial dosage appears to cause discomfort due to sulfur odor or taste fewer drops can be added to each glass of water until larger amounts can be tolerated easily and without distaste.

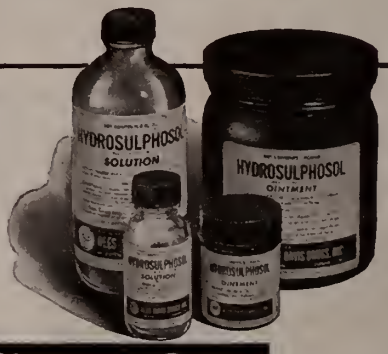
**OINTMENT:** Rub Hydrosulphosol Ointment over stiff joints, dry skin or affected areas once or twice daily.

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may be a *symptom* of

1. Intolerance to milk proteins
2. Low unsaturated fatty acid content of blood lipids.



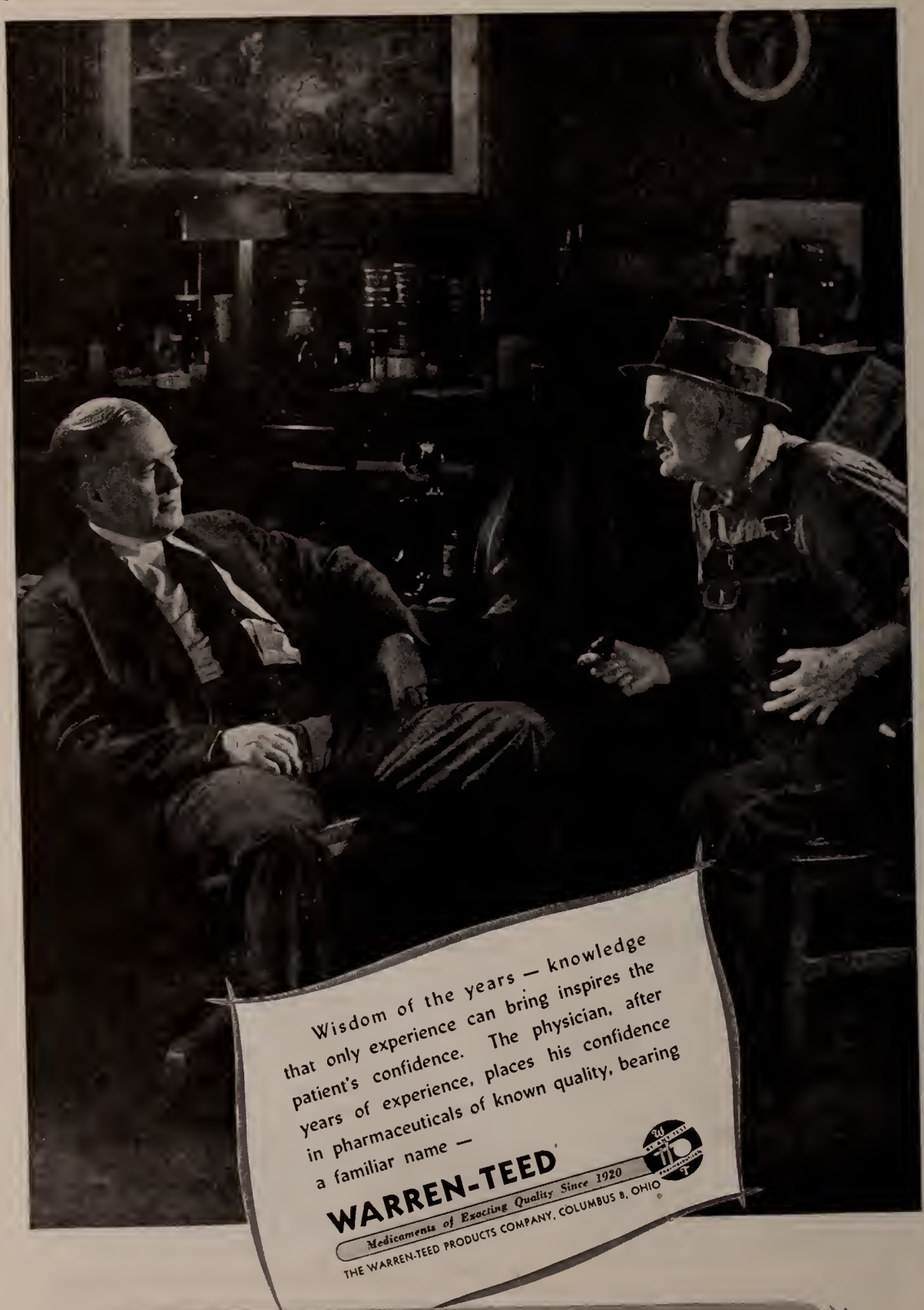

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Early studies[1,2,3] using foods rich in unsaturated fatty acids showed satisfactory results in eczematous conditions. • In more recent investigations MULL-SOY has been used as a hypoallergenic milk substitute. This liquid emulsified soy food contains only the non-milk proteins, and is a rich source of unsaturated fatty acids, particularly linoleic, which appears to be essential for maintaining skin integrity. In the report[4] of this work, it was stated: "When external treatment of the skin is of the best and a good elimination diet is employed a soybean food can produce a beneficial effect in eczema of infants and children both in the milk-sensitive patients and in the multiple-food-sensitive cases."

REFERENCES: 1. Combleet, T. and Pace, E. R.: Arch. Derm. & Syph., 31:224, 1935. 2. Hansen, A. E.: Am. J. Dis. Child., 63:933, 1937. 3. Taub, S. J. and Zakon, S. J.: J. A. M. A., 105:1675, 1935. 4. Stoesser, A. V.: Ann. Allergy, 2:404, 1944.

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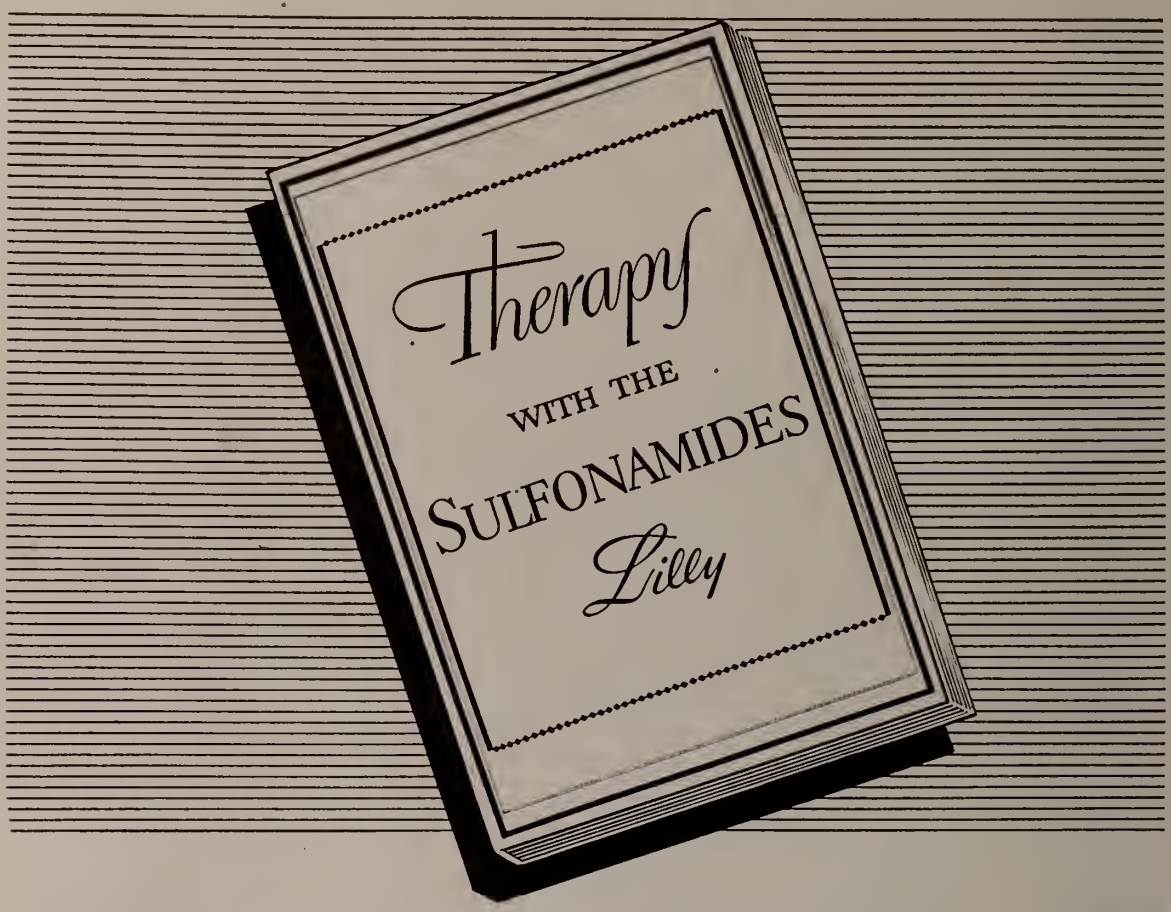
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*Active ingredients:*
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In 1937 sulfanilamide was introduced into general clinical use. During the next six years sulfapyridine, sulfathiazole, sulfadiazine, and sulfamerazine followed in rapid succession. The vast clinical literature which has accumulated in the interval has been carefully organized and condensed by the Lilly Research Laboratories into an eighty-three-page book entitled *Therapy with the Sulfonamides*. A bibliography of 323 references is included. The discussion is divided between systemic and local administration. Many helpful charts, including "Sulfonamides in Order of Choice for Systemic Use," "Dosage of Sulfonamides for Adults," and "Dosage of Sulfonamides for Infants and Children," are included. Request a free copy of *Therapy with the Sulfonamides* from the Lilly medical service representative or direct from Indianapolis. Sulfonamides, Lilly, for systemic and local administration are provided in a complete variety of dosage forms, subject to your specifications.

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# *Equal to any emergency*

EVEN during his infrequent intervals of relaxation the physician's professional services are likely to be in demand. Young athletes require care that only a competent authority can provide. Prompt attention to a bruised knee, a sprained wrist, or a twisted ankle may prevent serious damage. And so it is that the physician often may be found in the stands at a baseball game, in the gallery at a tennis match, or on the bench at a football contest, prepared for any emergency that may arise.

The manufacturer of drugs and medicines also renders a service peculiar to him alone. During ordinary times his task is none too difficult, but he must be prepared to meet any emergency. In times of stress, production must be increased, distribution accelerated. During the recent horrifying crisis that engulfed the world, demand for new and better biological agents, improved pharmaceuticals, and blood plasma reached an unprecedented high. Eli Lilly and Company is proud of the fact that it was able to respond to wartime demands in full measure, without imposing serious inconvenience on civilian physician, pharmacist, or patient. Remaining shortages are rapidly disappearing.

*A picture of The Good Samaritan provided the inspiration that*



*eventually led to the founding of Eli Lilly and Company*

October, 1946

VOL. 90, NO. 4

# The Illinois Medical Journal

Official Journal of the Illinois State Medical Society

EDITOR — Harold M. Camp. EDITORIAL BOARD — James H. Hutton, Chairman, Frederick H. Falls, Josiah J. Moore, Edwin M. Miller, Chauncey C. Maher, Harry S. Gradle, Harry Culver, Walter Stevenson, Raymond W. McNealy.

## Editorials

### IS DEMEROL HABIT FORMING?

In the June issue of The READER'S DIGEST, Paul de Kruif had an article entitled "God's Own Medicine — 1946" under the headline, "The pain-fighting power of demerol is as miraculous as that of morphine — without the opiates' danger of addiction."

An interesting letter to the Editor of the Journal of the A.M.A. was published in the July 13th issue, and signed by H. J. Anslinger, Washington, D. C., Commissioner of Narcotics, commenting on this article by de Kruif and referring to the fact that Demerol was placed under Federal Narcotic control by Congress because of evidence given before that body of its dangerous properties. This letter states that:

"The drug was introduced in the United States under the name Demerol. Its addiction properties were found to be similar to morphine by the United States Public Health Service Hospital at Lexington, Ky., where scientific studies in this field are the best in the world. This was confirmed by others who experimented with the drug." . . . . .

"I fear a wave of Demerol addiction if physicians who read this article believe what I consider the reckless and dangerous statements made by de Kruif that the drug is free from addiction properties. This is information somewhat similar to that which appears in the circular distributed by the manufacturer of Demerol to push sales. Had this article been prepared on a strictly scientific basis it would have sounded a strong warning about the danger of addiction. Our files contain numerous cases of addiction involving the use of Demerol. I cannot too strongly warn the members of your Association about the danger of addiction to Demerol."

There have been many articles appearing in popular magazines in recent years by enthusiastic writers, almost invariably not medically trained. They endeavor to give the latest advances in medical science, but unfortunately neither the writer nor the magazine (in most instances) ask for careful editing by someone with scientific background capable of evaluating the worth of the preparation or precedure under consideration.

Paul de Kruif has written a number of these articles and several have been published in the Reader's Digest, usually dramatizing some "recent medical discovery", but invariably failing to present its limitations or perhaps its dangers. No doubt many thousands of people, and some of them members of the medical profession may be caught off guard and take this article too literally, and eventually add to the miseries so often encountered through drug addiction.

In the several new additions of drug encyclopedias or pharmacologies recently coming to our attention, in which Demerol Hydrochloride is listed, there appears invariably, the warning that the drug is a narcotic and may be habit forming. But, this is not even insinuated in the Reader's Digest article, which to the contrary

states: "the pain-fighting power of Demerol is as miraculous as that of morphine without the opiate's danger of addiction."

It is quite obvious too that great harm can be done through this type of dramatized publicity by giving a false sense of security to many people who believe their ailments can be relieved by the new drug or by some form of treatment which is the subject of the magazine article.

We well recall that following the glowing account of relief for the deaf through the fenestration operation, literally hundreds of letters were received in the Society offices asking where this skillful operation could be performed. We naturally had to tell them that the fenestration operation was limited in its benefits to a few cases of a particular type of deafness, and that only a few specialists were doing this operation. Our only recommendation was that they endeavor to arrange for an appointment with one of them and abide by his decision. At that time these surgeons were booked months ahead, one having operations scheduled as far as 8 to 10 months in advance. They naturally did not want so much of their time taken up by people having had some form of deafness for years and which are not of the right type to be relieved by this surgical procedure.

Likewise following the graphic description of the "new" and easy available remedy for the quick relief of "athlete's foot", many letters were received asking for the exact procedure for its use, and many letters had to go out with the usual warning as to the danger of the two chemicals recommended by the author of the article.

If the American people would get their health information from those trained in health and medical activities, they would receive better advice and would be relieved of many of the disappointments that are sure to follow the application of those procedures recommended by laymen in publicity appearing in magazines, newspapers or over the radio.

Once more we would recommend to the Read-


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er's Digest that they have a medical editor to whom articles on health subjects can be referred so that they can be checked for authenticity of statements contained therein.

## WANTED: GENERAL PRACTIONERS

Following the end of World War II literally thousands of younger physicians and some of the older ones who were in the medical corps, decided to specialize and are now taking intensive courses. Many of these men formerly were in general practice, perhaps in a small community. They have realized that they can make more in a limited time by entering a specialty and have fewer demands on their after-office hours. Like men in other professions and business fields, they desire to do everything possible to help themselves and their families.

On the other hand there is an increasing demand everywhere for men interested in the general practice of medicine. The House of Delegates of the American Medical Association created a Section on the General Practice of Medicine, and this venture has proved to be a popular one. It has been recommended that all state societies likewise create such a section in keeping with the action of the A.M.A.

Some years ago it was the general concensus of opinion in medical circles that men in medical schools should become general practitioners and practice as such for periods of perhaps from five to ten years; then if they so desire, they should specialize. This type of background naturally aids the man in any specialty who has had the basic training that only general practice can give. Today many of the undergraduates, if not the majority of them, plan while in school to go into some specialty.

In our work during the war with Procurement and Assignment Service for Physicians, and later in cooperation with the A.M.A. Bureau of Information, in endeavoring to aid in the relocation of physicians returning from service, we were interested especially in the types of letters received asking for a physician. Almost invariably instead of specialists, every community needed more general practitioners.

In one unusually large county in Illinois when efforts were made to keep definite information on the physician-population ratio, we were constantly reminded that the county did not have enough general practitioners, and that the majority of their physicians were specialists. This frequently was considered an incentive for limiting the number of available physicians as a function of the Procurement and Assignment Service.

Lawyers specialize, and likewise men in other professions and business endeavors. Physicians naturally have this same right. It has been recommended by some that young physicians following completion of their internship be required to spend at least three years in general practice before starting a residency with the intention of specializing. This no doubt would add materially to the number of general practitioners even in the rural areas, and it might possibly fill the demands, as there would be new recruits going into this general field each year, thus maintaining approximately the same number all the time.

Again with this basic training as general practitioners, physicians learn many things which will be to their advantage later when they become specialists. If arrangements could be made to lessen the number of younger men going into special fields without previous training in general work, it would most likely go a long way toward overcoming much of the opposition that has been manifest in hearings before Congressional Committees, (such as we have recently observed in the transactions of the hearings on the Wagner-Murray-Dingell and similar bills pending in the Congress).

## ILLINOIS INTERPROFESSIONAL COUNCIL

In 1940 members of the Illinois State Medical Society, Illinois State Dental Society and the Illinois Pharmaceutical Association met to consider the formation of an interprofessional council to meet at regular intervals and consider many of the mutual problems of these allied professional groups. After holding several meetings, a Constitution and By-Laws were drawn up, to be submitted to the Councils of the respective groups for their consideration and eventual approval.

The purpose, as brought out in the Constitution, is as follows: "The purposes of this Council are: to promote the science and the art of the practice of the aforesaid professions in so far

as they affect the progress, the development and the practice of the 'healing arts' in the state of Illinois; to lend support to the program in matters of common interest shared by other health agencies engaged in the control or the eradication of diseases that endanger human life; to cooperate with state and government agencies having for their purpose the dissemination of public health information which we believe will improve hygienic standards of living in the State of Illinois."

It is proposed that each of the participating organizations have two official representatives on the Council, these from the Medical, Dental, Pharmaceutical and Nursing professions, these being elected for terms of two years or until their successors are duly appointed and qualified.

The proposed Constitution and By-Laws were submitted to the Council of the Illinois State Medical Society early in 1941, was referred to a committee for study, then to the Committee on Constitution and By-Laws for critical review before it was referred back to the Council for final action. It was likewise referred to the House of Delegates at the 1941 annual meeting, and was re-referred back to the Council for final approval. When the war broke out, the entire matter was held in abeyance as all participating organizations were actively engaged in the war effort.

The Illinois State Dental Society through its Executive Council, in session on May 14, 1941, with a few minor changes in the submitted copy, gave approval to the Constitution and By-Laws. At the annual meeting of the Illinois State Medical Society held in Chicago last May, this matter was referred to the house of Delegates which approved the proposed Constitution and By-Laws in principle, but authorized the Council to go over the draft carefully and if satisfactory, give final approval for the Society.

At a meeting of the Council on September 8, 1946, the Committee on Constitution and By-Laws reported to the Council, making only a few grammatical changes, and gave approval to the plan, and authorized the participation of the Illinois State Medical Society in the Illinois Interprofessional Council. The Constitution and By-Laws will be published in the next issue of the Illinois Medical Journal so that membership at large will be thoroughly familiar with the set-up and know what is expected of them in the successful operation of this new Interprofessional Council.

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## AMERICAN PHYSICIANS ART ASSOCIATION

From July 1 to 5, 1946, in the War Memorial Opera House in San Francisco, the eighth annual exhibition of the American Physicians Art Association was held under the sponsorship of Mead Johnson & Company.

The summary of exhibits and the awards have been published, among the men participating were many from Illinois. We have felt that this work and these interesting activities should be called to the attention of other professional men, and we list here our Illinois physicians and their 1946 contributions to art.

Amromin, George D., Chicago
"Grandfather" (Oil) Award of Merit
Bailey, Ralph J., Chicago
"Our Lady in the Moon" (Wood Carving)
"Baby Seal" (Wood Carving) Award of Merit
Balogh, Stefan H., Chicago
Christmas Card (Drawing)
Christmas Card (Drawing)
Bauer, W. W., Wilmette
"Sawbill Shore" (Oil)
"Sawbill Cottage" (Oil)
"Sawbill Wharf" (Water Color)
Beiser, Helen R., Chicago
"Olive Tree" (Pastel) — Award of Merit
"Staff" — Illinois Neuropsychiatric Institute (Drawing)
"Flowering Quince" (Tempera)
"Spring — Kern County" (Water Color)
Bellas, Joseph E., Peoria
"Aleutian Adventure" (Oil) — Award of Merit
"River Rat" (Oil)
"Camp Mates" (Oil)
DeCosta, Edwin J., Chicago
"Prize Fight" (Water Color)
Fitzmaurice, H. A., Chicago
"A Male Nude Running" (Plaster) — 1st Prize
Giltner, O. B., Sheffield
"Dad's Service Pipe" (Wood Carving) — Award of Merit
"Manzanita Costume Jewelry" (Wood Carving)
Harris, Leonard H., Peoria
"Garden Gates Waikiki" (Photography)
"Koko Head Nocturne" (Photography)
Hayden, Daniel B., Chicago
"Surrealistic Ear" (Water Color)
Heifetz, Milton D., Cicero
"Refuge" (Sculpture) — 2nd Prize
Johnson, T. Arthur, Rockford
"Sharing" (Photography, Color)
"Shadows in the Street" (Photography, Color)

"Sunrise in the Philippines" (Oil)
"Teen-Ager" (Oil)
Kraus, John E., Peoria
"The Monk and the Devil" (Oil)
"Greek Sailor" (Oil) — Award of Merit
Laufman, Harold, Chicago
"An Old Arab Money-Changer" (Pen and Ink)
Levy, Herman A., Chicago
"Chess Board" (Metal Work) — Award of Merit
Macherey, William F., Chicago
"Sunset" (Oil)
Merricks, James W., Chicago
"The Mayo Clinic" (Drawing)
Oster, Jack H., Chicago
"Fun in the Park" (Photography)
"Shepherd" (Photography)
"Dusk" (Photography, Color)
"Young Art Student" (Photography, Color)
Perl, John I., Chicago
"Still Fishing" (Oil)
"Demolition Workers" (Oil) — First Prize
"Dr. Rudolph Oden" (Tempera)
"Around Noon at Olson's" (Gouache)
Perret, George, Chicago
"Still Life" (Water Color)
"Steam Shovel" (Water Color)
Rappaport, Ben Z., Glencoe
"The Round Table" (Oil)
"Still Life with Open Book" (Oil) — 1st prize
Raymond, Beatrice, Chicago
"Till the End of Time" (Oil)
"Etiology, Dr. Lawless" (Oil)
Stein, M. F., Chicago
"In a Persian Market" (Oil)
"Defeat" (Oil) — 1st Prize
Thorek, Max, Chicago
"Driftwood" — (Photography)
"Clay" (Photography)
"Vale of Years" (Photography)
"Patience" (Photography)
"Stephen Foster, In Memoriam" (Photography)
"Contentment" (Photography) — 2nd Prize

The first annual exhibit of the American Physicians Literary Guild was also held, and among the unpublished manuscripts on display were those of two Illinois physicians. Dr. Noah D. Fabricant of Chicago had a short story, "Young Men on a Carousel", and Dr. Bernard Klein of Joliet two works of fiction, "The Power of Silence" and "The Mighty Link".

As this catalogue quotes from Sir William Osler:

"One cannot practice medicine alone, and practice it early and late, as so many of us have to do, and hope to escape the malign influence of a routine life", so in the fields of art, Illinois physicians have found an escape from the monotony of routine, and developed hobbies and artistic attributes as a means of relaxation and relief.

## "USE YOUR OWN PRESCRIPTION BLANKS"

An editorial appeared in the September issue of the Connecticut State Medical Journal on this subject, which should be read by physicians everywhere as it pertains to a subject of general interest. Attention was called to the conference which was held in 1941 with representatives of the State Medical Society and the State Pharmaceutical Association present, and following a general discussion, the following principles were adopted:

"The use of prescription blanks bearing a pharmacist's name is bound to be misunderstood and has no justification whatever. We recommend that the Connecticut State Medical Society adopt a policy urging physicians to use blank prescription forms."

A joint conference committee with representation from the state medical society and the state pharmaceutical association was formed and meets at stated intervals. We were told that three conferences have been held this year, and the above principle has been approved each year by the group since its formation in 1941.

Pharmacists should cease publishing their names on prescription blanks bearing the name of a physician. It has been our belief for many years that every physician should have his own prescription blanks printed so that the one to whom the prescription has been issued may go to the pharmacy of his choice to have it filled. Although not strictly an act of compulsion, the name and address of a pharmacy on the blank naturally leads many to believe that they must take it to the pharmacist whose name appears on the blank. Formerly the words "Take to the ————Drug Store" appeared on the form, but fortunately this statement is rarely seen today.

An editorial in this issue of the Illinois Medical Journal gives information on the Interprofessional Council which was organized some six years ago, but which was temporarily suspended at the outbreak of the war when the allied professions were all engaged in efforts to aid in wining the war, and with so many members of all professions in the armed forces.

Now that the conflict has ended, it seems de-

sirable to give consideration to this effort to improve the relations between the medical, dental, and the allied professions and the subject of pharmacists' names on prescription blanks should be considered by the Council in the near future.

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## RESIGNATION OF JEAN McARTHUR

Jean McArthur, who has efficiently held the position of Secretary of the Educational Committee of the Illinois State Medical Society for the past nineteen years, retired following the submission of a letter of resignation as of October 12, 1946.

Miss McArthur came into this office some three years following the organization of the Educational Committee, first known as the Lay Educational Committee, and has been in great measure responsible for the fine work which has been done over the period of years. The Illinois State Medical Society, pioneering in this type of work, has built up an enviable reputation through the work accomplished through this committee, which has always had an unusually interested membership to direct its activities.

Starting off with efforts to aid many organizations in developing programs at which health subjects were presented the committee, through the guidance of Miss McArthur, years ago began to furnish speakers for many hundreds of organizations throughout the state. Then when the use of the radio became more popular, as many as 500 radio health talks were presented during the year, all of which were prepared and presented by members of the State Medical Society after they were primarily solicited by Miss McArthur, and the copy carefully checked by the entire committee.

Whenever epidemics were prevalent in any section of the state, the committee was asked to hurriedly select speakers to talk on the radio on that particular subject. Years ago, releases on health subjects were prepared under the supervision of Miss McArthur and were sent to a mailing list of several thousand, these going to schools, various types of organizations, industrial plants, and to all others who asked to be placed on the mailing list.

As many as 250 newspapers throughout Illinois have received regularly, health columns, some presented daily, others two or more times each week, while in other instances, the weekly paper carried this health column, which invariably appeared under the sponsorship of the local county medical society.

This type of public relations first established in the Illinois State Medical Society in 1923, has been worth much indeed, to the medical profession of Illinois and more perhaps, to those who have benefited through the programs which have been arranged for them, those who have received the many releases sent out regularly, and the listeners tuned in to the radio health talks.

Under the guidance of Miss McArthur, hundreds of packets have been arranged in a package library, containing material on the various phases of health, and material desired by hundreds of college, university and high school students to prepare material for debates on health or medical economics subjects.

Some eighteen years ago, the Scientific Service Committee was organized and functioned through the Educational Committee office in Chicago, this to give service to the component medical societies. Speakers and subjects were listed in a handbook which was sent to all county medical societies, they in turn would select the speakers and subjects of choice, and the committee would arrange to have the speakers of choice appear on the program. In many instances, the announcements for the meeting were sent from the Society office as facilities were available for mimeographing, and addressing the material to be sent out. These varied from one society having weekly meetings all arranged by the Scientific Service Committee, to bimonthly meetings, monthly, or quarterly meetings depending on the individual societies to be serviced.

About eight years ago, the Post-Graduate Committee was formed, and it too functioned through the Educational Committee office, with Miss McArthur assuming in great measure, responsibility for selecting speakers for these refresher courses. During the present fiscal year, ten post-graduate conferences have been arranged, and these are usually all day meetings, with some six to eight speakers, round table discussions in the late afternoon, and an evening dinner meeting with at least one speaker for the evening session. These conferences have been greatly appreciated by the membership as a

(*Continued on page* 232)

# State Department of Public Health

## PUBLIC HEALTH PROBLEMS

ROLAND R. CROSS, M. D.
Director, State Department of Public Health
SPRINGFIELD

I take it that all of you are well aware of the medical aspects of public health problems and of the large potential possibilities of preventive medicine. I need not remind you that diphtheria is preventable or that a dozen other communicable diseases are subject to a high degree of control. I need not describe for you the technical methods, such as vaccination, sanitation and sterilization, that must be employed in good season with no little skill in the liquidation of contagious and infectious ills. I need not weary you with a recitation of the monumental advancements in scientific knowledge as to nutrition, chemo-therapy, insecticides, surgery, immunology and other specialties which may be used to the profound advantage of the public health.

You know all of that already. You, no less than we, are anxious to apply that knowledge to the limit of your ability. The principal public health problem which faces us at this time is rather the ways and means of applying the knowledge we have so that the public will reap the greatest possible benefits that science has to offer in the way of improved health. In regard to a large part of our health problems we know what to do and we know how to do it. What is needed is the machinery for doing the job. Setting up adequate and efficient machinery that will operate satisfactorily and effectively is the most important unsolved public health problem in Illinois today.

In my opinion we have in Illinois a State Department of Public Health second to none in efficiency. If all vacancies on the professional staff were filled, the strength of this agency might be as great as it is desirable to make it. Certainly no substantial growth or expansion would be called for under my philosophy of government. What we do need and need badly is a substantial development and growth of local public health machinery. Lack of local public health machinery is the weakest point in the public health program in Illinois at this time. The remedy of this weakness would have three important results. (1) It would pay big dividends in improved health conditions; (2) it would strengthen the home rule principle and check the trend toward centralized government; (3) and it would help to prevent socialized medicine.

A factor of overshadowing importance in the improvement of local health machinery is a united front on the part of the medical profession and the public health authorities. This must result from a spirit of good will and of mutual respect and confidence. There is no valid reason that I know of why the doctor in private practice and the health officer should not work shoulder to shoulder. The end in view of both is the same—improved health. Each can render services that the other cannot perform but which are of re-

ciprocal value and which are advantageous to the public health.

In connection with this general line of thought the recent war demonstrated overwhelmingly, two or three things, among many others of direct bearing on public health service. One was that the moment public health machinery is impaired or destroyed all of the gains of preventive medicine may be quickly lost. Another was that agencies with long traditions as independent organizations can work together in harmony and under a general over-all plan to great advantage in the achievement of a common goal. In all of the belligerent nations of Central Europe where public health machinery was sacrificed to military needs all of the gains in preventive medicine were lost. Diphtheria, for example, swept across these nations in a great and deadly epidemic wave. Typhoid fever has been widespread. The tuberculosis rate has risen far above the pre-war level. Infant mortality has climbed substantially. The venereal diseases are commonplace.

On the other hand, there was an actual improvement in these rates during the war years in the British Isles where the integrity of the public health services was maintained and where rationing of foods was carried out on a scientific basis. While the British Isles were not invaded, they were not spared the destructive effect of bombs. Shortages of all kinds were severe and the destruction of public facilities such as water supply and sewage disposal systems and hospitals was great. In the face of this tremendous strain an actual improvement in the public health was achieved because the local public health machinery was maintained and strengthened.

Similarly in Switzerland which managed to stay out of the conflict, the public health machinery was maintained. There, as in England, there was no loss of the gains of preventive medicine. None of the controllable communicable diseases have increased beyond pre-war experience.

It may be pointed out, moreover, that experience in Denmark and certain parts of Russia demonstrated again and under the most severe tests the value of immunization against diphtheria. Good records from local areas show that practically no deaths from diphtheria occurred among persons who had received toxoid treatments in standard dosage. Although a considerable number of treated persons got the disease, available records show no deaths among them. On the other hand, mortality among the non-treated was as high as 35 per cent in some groups and ranged around 20 per cent generally.

This unplanned and unparralleled demonstration should remove forever any doubts that may have existed as to the effectiveness of local public health machinery and as to the effectiveness of specific preventive measures.

As to the ability of independent agencies to work together, our own military forces demonstrated the value of cooperation and coordination in the execution of a general plan. New words and phrases which crept into our language illustrate what I mean. Among these are such striking phrases as "all out," "black out," "total war," "combined operations," unified command," "combined staff," and "one world." These and many others of similar implication point to a new conception of cooperation. The old idea was "team work" in each of many groups operating independently. The new idea is that all independent groups or teams working toward a common purpose should be so related as to bring their combined efforts and resources to bear on the problem that needs solution.

That this new idea will work and work well was demonstrated by the military forces and by civilian industry during the war. I believe that it can and should be applied in the field of health protection and improvement. I believe that the resources and services of all health agencies, both official and voluntary, can be coordinated and integrated in a way that will result in overwhelming public advantage at no serious loss to any agency concerned.

Let us remember that the Army, Navy, the Marines, the Red Cross and the USO worked together on all fronts as a single, well oiled machine. The marine was still a marine and retained all of the distinction and all of the traditions of that famous organization. So it was with the soldier, sailor, the Red Cross worker and the USO employee. They worked together according to an over-all plan because they wanted our side to win the war. Victory for the nation meant victory alike for each organization and for each

person in the nation. All shared alike in the fruits of triumph.

In the health field we face a situation similar in many respects to that faced by the nation when war came. The enemies to health are numerous and ruthless. We have built up a lot of agencies both official and voluntary with which to fight these enemies, the various diseases and other hazards to good living. The aim and purpose of each of these agencies is the same—*better health for more people.* We should get together so as to bring the full weight of our combined operations on the problem that is common to us all.

From the public health point of view, as I have said already, the greatest single need at this time in Illinois and throughout the nation is the improvement in local public health machinery. This opinion is shared by organized medicine and by the leading public health authorities of the nation. On June 10, 1942, for example, the House of Delegates of the American Medical Association unanimously adopted a resolution favoring the extension of local public health services. That position has been officially restated on several subsequent occasions. The Council of the Illinois Medical Society not only endorsed the legislation which permits the establishment of county health departments but has gone on record in favor of the establishment of county health departments. By and large this attitude prevails among County Medical Societies. Here in McLean County, the Medical Society took the lead in bringing about a favorable vote which will give the county a health department the first of next month. In Will County, the President of the Will-Grundy Medical Society is chairman of the steering committee which has arranged for a vote on the county health department proposition next November. In like manner the local medical societies have been active in several other counties. This is as it should be.

Another pressing need is for more hospital facilities and the improvement of procedures in existing hospitals, particularly in maternity and pediatric departments. We know that hospitals are not well distributed to meet the needs in Illinois. We know also that some institutions which pass for hospitals make no pretense at giving hospital care in the modern meaning of that term. Unhappily, the areas with an acute shortage of beds are the same in which are found the highest proportion of poorly equipped and poorly staffed hospitals. There are 29 counties which have no hospital facilities of any kind. There are 23 others which have institutions that appear to be hospitals in name only. Thus, fully one-half of the counties in Illiinois are known to be without local hospital facilities that may be rightly classed as such. Many of these counties are contiguous. Most of them are in the southern part of the State. The prevailing health conditions in these counties are reflected in higher death rates and higher sickness rates from controllable causes. Obviously we need a substantial expansion in hospital facilities.

We have learned lately by experience with infantile diarrhea that the practices and procedures in some of our better hospitals need improvement. Since 1941 there have been nine outbreaks of epidemic diarrhea of the newborn in down-state hospitals. In these nine outbreaks there were approximately 225 reported cases and 74 deaths. At one hospital (St· Josephs in Alton) the death rate was 63 per cent. Four of the outbreaks accounting for 70 odd cases and 34 deaths occurred during 1946. All of us wish alike to prevent such disasters. It can only be done by working together. It can best be done under the guidance and with the help of adequate local public health machinery manned by competent well trained personnel.

The first steps toward solving the hospital problem, both as to new construction and to improved standards, have been taken already. The Department of Public Health, after authorization by the Governor, undertook a detailed survey of the hospital facilities and the hospital needs of the State. The collection of the information is almost complete. When the data is assembled it will be submitted for study to a State Advisory Council on Hospitals, appointed by the Governor and consisting of 50 members. That Council, on which is represented the medical, nursing, hospital and other interests, will develop a long-range construction plan and minimum standards of operation. New hospital construction projects which fit into that plan will be eligible for Government aid in the event that pending legislation passes.* Conformity to that

* Now a law; approved August 13, 1946.

plan will prevent over-building in the wealthier areas and it will encourage adequate construction in the less favored areas. It will also encourage high standards of hospital operation.

The first steps have also been taken in the promotion of more adequate local health departments. A law that permits the establishment of county health departments was passed in 1943. Since that time 16 counties have taken official action to set up health departments under the provisions of the law. Four of these were established by popular vote. They are Adams, DuPage, McLean and Montgomery. Arrangements are being made to submit the proposition to popular vote next November in some 15 or 20 other counties.

The success of these elections and those to follow, and the success of the hospital improvement project, will lay a solid foundation for the solution of our public health problems. With the machinery which these projects would provide every public health problem can be attacked under the most promising conditions for success.

As to what the people think, all of us know very well that throughout the world there is a strong current of public opinion in favor of making the benefits of scientific knowledge more generally available for both the cure and prevention of disease. In the United States this current of public opinion has expressed itself in many ways. Numerous bills have been introduced in Congress, for example. I, myself, was roundly called to task by several Senators during the last regular session of the General Assembly for not having requested an appropriation for a cancer hospital. Our General Assembly did appropriate money for the construction of tuberculosis sanatoria. It also created two commissions to study the needs for hospital expansion and for extending medical care. A great labor union was willing to shut down an essential industry to win a bargain that provides a health and welfare program. Admiral Boone and a party of experts are in Illinois today on an inspection tour of the mines to appraise the condition and needs so as to implement the health program intelligently. The railroad brotherhoods caused the enactment of a law in Illinois last year which requires the inspection and improvement of hotels and lodging houses from a sanitary and hygienic point of view. Voluntary agencies devoted to the control of tuberculosis, poliomyelitis and cancer have little trouble in raising huge sums for the control of those diseases. Delegations frequently come to Springfield seeking aid to provide all kinds of local health services.

The people who initiate these demands are in dead earnest. They have no personal axe to grind, most of them. They have recognized shortcomings in their health protective services. They have come to regard health protection and health promotion as a right and not only a privilege. They turn naturally to their Government for the services which they have been taught to believe are important to public and individual health.

Our situation is clear and unequivocal. We are face to face with such unsolved problems as tuberculosis, cancer, nutritional deficiencies, mental disorders, the venereal infections, occupational diseases, rheumatism, epidemic diarrhea of the newborn and a host of others. We have much more knowledge than we are using to the best advantage in this respect. The public is restive that more should be done. It has been demonstrated that adequate local health machinery and hospital facilities under skillful management are the best means at hand for utilizing our knowledge to the fullest degree. Let us work together to bring these things about.

# Correspondence

## CHICAGO MEDICAL SOCIETY ANNOUNCES CLINICAL CONFERENCE

The Third Annual Clinical Conference of the Chicago Medical Society will be held at the Palmer House, Chicago on March 4, 5, 6, and 7, 1947. Prominent men in medicine from all sections of the United States will take part in the program.

## MEETING IN OMAHA

The Omaha Mid-West Clinical Society will hold its Fourteenth Annual Assembly in Omaha October 28th to November 1st, inclusive, at Hotel Paxton.

There will be seven panel discussions on timely subjects, and the program will again include motion pictures, scientific and technical exhibits, clinics and question and answer periods following luncheons and dinners.

## INFECTIOUS HEPATITIS IS REPORTABLE

To the Editor:

Infectious hepatitis was probably the most widespread disease during World War II, and reached epidemic proportions in many places throughout the world.

This disease was made reportable in the State of Illinois in 1943 and to date only 472 cases have been reported.

The exhibit of Dr. M. Herbert Barker on infectious hepatitis during the recent Chicago Clinical Conference and the Illinois State Medical Society Meeting aroused considerable discussion and indicated that a surprisingly large numer of cases were occurring which had not been reported to the Department of Public Health.

In order that the problems of infectious hepatitis may be studied in Illinois, it is necessary that all cases be reported and I would appreciate your calling this to the attention of Illinois physicians through the columns of the Illinois Medical Journal.

Very truly yours,
Roland R. Cross, M.D.
Director of Public Health
State of Illinois

## VETERANS ADMINISTRATION NEEDS TB SPECIALISTS

Doctor Delmar Goode, Branch Medical Director, has stressed the urgent need for physicians interested in tuberculosis and tuberculosis specialists in the Veterans Administration. This is particularly true of the Veteran's Hospitals in Wisconsin, Indiana and Illinois.

Numerous positions are immediately available with salaries ranging up to $11,000 per annum, depending upon training and experience. There are opportunities for post-graduate work and individual research.

Applications may be obtained by addressing Doctor Delmar Goode, Branch Medical Director, Veterans Administration Branch Office No. 7, 226 W. Jackson Boulevard, Chicago 6, Illinois.

The Ambulatory Fracture Association will meet in Galesburg on November 14, 15, 16.

# Original Articles

## THE MANAGEMENT OF PERSISTENT OCCIPUT POSTERIOR

With a Note on the Technic of Forceps Rotation by the Stillman Procedure

D. N. Danforth, M.D.
CHICAGO

Occiput posterior position is one of the more common obstetric complications, and if improperly evaluated and managed it gives great opportunity for the infliction of birth injuries upon both mother and baby. The respect which this complication deserves has in effect been diminished by recent papers which show that the posterior position is to be considered normal in certain types of pelvis, that the great majority of posteriors will rotate to the anterior without interference, and by those which purport to demonstrate that the character of labor in posterior is not notably different from that of the normal anterior mechanism. Despite these implications the fact remains that some 30% of posteriors persist as such, and constitute potential catastrophes if improperly managed. The difficulties encountered are immeasurably increased by failure to appreciate the possible eventualities and by the lack of a rationale which covers them. It is the purpose of this paper to consider the subject of the persistent occiput posterior mechanism with reference to etiology, the management of the first and second stages of labor, and a method of forceps rotation which has proven emminently successful.

I. *Etiology of the Posterior Mechanism at Term.* It has been amply demonstrated that under ordinary circumstances pelvic configuration plays a dominant role in determining the mechanism of the vertex in labor. It is further shown that careful clinical examination near term may enable one to predict with reasonable accuracy those cases in which the posterior mechanism will obtain and, of these, certain instances in which spontaneous rotation is likely not to occur. The portions of the pelvis which are most accessible for clinical examination are the following:

1) Forepelvis.
2) Ischial Spines and Inclination of the Side Walls.
3) Curvature and Inclination of the Sacrum.
4) Subpubic Arch.
5) Transverse of the Outlet.
6) Diagonal Conjugate.

For purposes of illustration it is permissible to consider the occiput as the "heaviest" portion of the fetal head, and to consider that this "heaviest" portion will ordinarily tend to "gravitate" to the largest part of the pelvis at the particular station which the head occupies at the moment. If this conception is followed and the above features are carefully evaluated either clinically or, in cases of doubt, by x-ray pelvimetry, then the following relationships are apparent:

(A) At the *inlet* engagement in the posterior is most likely in the presence of narrow forepelvis and ample posterior pelvis at this level.

(B) Features in the *midpelvis* which favor persistence of the occiput posterior are relatively deep sacrum at this level, plus either prominent spines or converging sidewalls which would impinge upon the biparietal or narrowest diameter of the fetal head and counteract any tendency

From the Department of Obstetrics and Gynecology, Northwestern University Medical School, Chicago.

to anterior rotation. The narrowed forepelvis also may exert an influence upon midpelvic mechanism, further limiting the space for anterior rotation.

(C) At the *outlet* there is the tendency for anterior rotation as the occiput impinges upon a forward lower sacrum or upon the pelvic floor. This tendency may be effectively offset by narrowing of the subpubic arch and transverse of the outlet, together with a fully adequate posterior pelvis at this level.

It is emphasized that it is neither sufficient to simply label the pelvis as being of one type or another, or to have only partial knowledge of the pelvis with which one is dealing. Rather, one should acquaint himself with each of the pelvic features, visualizing them both with respect to the other pelvic variables and to the fetal head whose mechanism they will determine. Such knowledge is considered as essential to the adequate management of the posterior mechanism. It is of inestimable value both in prognosticating the course of labor and in selecting the procedure of choice if interference becomes necessary.

II. *Character and Management of the First Stage of Labor.* It has been mentioned above that approximately 70% of occipito posterior mechanisms never approach the problem stage since they correct themselves spontaneously and are not accompanied by significant uterine incoordination. However, it is a common experience that of the 30% which ultimately do require aid, a significant number will first make themselves known by defects in the uterine contractions of the first stage of labor. These are manifest by uterine inertia of variable degree, and failure of cervical dilatation to proceed at its expected rate. It was emphasized by the late Dr. W. E. Caldwell that one of the factors essential for proper coordination is adequate stimulation of the lower pole of the uterus by the presenting part or by an intact bag of waters. Such stimulation or "fitting" of the head is optimum in the case of the anterior or early transverse mechanism of the occiput. In the instance of the occiput posterior the normal contours of the lower pole of the uterus are more apt to be distorted with the result of faulty and irregular fitting of the head, faulty stimulation of the lower pole, and consequent incoordination of the uterine musculature. Malpositions and malpresentations constitute one of the most important causes of uterine inertia and cervical dystocia; of these the occiput posterior position is one of the commonest offenders. It is sufficiently common that in unexplained inertia it is one of the first things which should be considered. The inertia which so often attends OP is generally of mild degree, and demands nothing more than recognition of its etiology, and management of the *symptom* of uterine inertia. Efforts here are directed toward maintaining the patient's hydration and nutrition, and the administration of sufficient sedatives to allay restlessness but not to interfere significantly with the progress of labor. *Irrespective of its speed, one should be satisfied so long as progress is being made however slowly,* and so long as the condition of both mother and baby remains good.

Caudal anesthesia should be used only with full realization that if instant intervention becomes necessary its difficulties may be greatly increased by improper uterine relaxation and by lack of preanesthetic medication. Deep ether is the anesthetic of choice for any intrauterine manipulation; where one cannot await the effect of adequate premedication its use imposes an extreme anesthetic hazard, and one which is best avoided by use of systemic analgesics in preference to caudal anesthesia.

*Intervention in the First Stage of Labor.*

(1) When 6 to 7 cm. dilatation is reached it is permissible to rupture the membranes artificially, employing sterile precautions, if labor has not been progressing at a normal rate. In any event the membranes should be ruptured artificially if they bulge well into the vagina or remain intact when full dilatation is reached. The latter instances suggest the possibility of abnormally thick membranes, and if allowed to remain intact they may by traction give rise to partial detachment of the placenta.

(2) In occasional instances inertia may be severe, or the uterine contractions though intense may be sufficiently incoordinated to interfere with cervical dilatation. In these cases it is not unusual to note the onset of fetal distress and maternal exhaustion, both of which if allowed to continue may lead to alarming circumstances. The onset of such a situation is generally preceded by a more or less absolute lack of progress of variable duration, and it is

during this period that one must pay particular attention to the general measures mentioned above. The question of the use of pituitrin often arises at this time. If it is used here, just as in any other obstetrical situation, a preparation should be selected which contains minimal amounts of the pressor fraction. Further, it should be used only in minute dosage, e.g., 1 minim every half hour for 3 doses. One should remember, however, that uterine inertia is merely a *sign* of abnormality elsewhere, that pitocin does nothing to relieve its cause, and that pitocin will rarely convert a desultory, ineffective labor into an efficient one; in most cases of inertia its main effect is merly to add to the patient's discomfort. Pitocin is extremely useful when combined with pudenal block as indicated below; by itself it generally serves little purpose and may be very dangerous.

*Operative intervention* during the first stage of labor must not be undertaken except upon the appearance of absolute fetal or maternal indication. Once intervention does appear necessary, it is well to recall that most obstetric catastrophies result directly from interference rather than from the lack of it. Procedures which are permissible during the first stage are limited since the carrying out of intrauterine manipulations through an undilated cervix is not to be sanctioned. Efforts at this time, therefore, are directed only toward the achievement of full dilatation, and may be undertaken only if the condition of the patient or the baby definitely indicates them. *Manual dilatation* is mentioned only to be condemned. Carefully placed *Duhrsen's incisions* may be made if other methods fail, though this procedure is not without danger. It should be used only when the head is deeply engaged, and when the cervix itself offers the only contraindication to delivery. General anesthesia should be sufficiently deep that the incisions will not be extended by the patient's voluntary efforts. Even with these precautions high upward extensions may occur; when contemplating cervical incision one should be prepared for this contingency. Far preferable to this procedure is Bunim's *pudendal block* method for obtaining full dilatation[1]. It is essentially without danger, and for this reason allows considerably greater latitude in its indications. If the injections are properly made following precisely the technic outlined by Bunim the results are often dramatic, full dilatation occurring within 20 or 30 minutes. In brief, a pudendal block is made after the manner indicated (freshly prepared 1% novocaine must be used), followed immediately by the subcutaneous administration of 2 minims of pitocin. This procedure should be done with the patient upon the delivery table and prepared for vaginal delivery. Pituitrin may be withheld if the pains are satisfactory, though in most cases it is a necessary adjunct. One's course following the achievement of full dilatation by this method is dependent primarily upon the circumstances and to a lesser degree upon the skill of the operator. If effective labor ensues it should be allowed to progress: if indications for further intervention are present the case may be managed after the manner indicated below.

III. *Intervention in the Second Stage of Labor.* As in other obstetrical operations, selection of the proper time for intervention is of just as fundamental importance as use of the correct procedure. It is generally stated arbitrarily that the second stage of labor should be terminated after 2 hours because of the danger either of uterine rupture or the formation of a pathological contraction ring. Both of these dangers are very real, and in the presence of violent second stage contractions this rule should be followed. However, so long as the contractions are of less than normal intensity (as is so often the case in OP), so long as gradual descent is occurring, and so long as the condition of mother and baby remains good, it is permissible in carefully selected cases to allow the second stage to continue under close observation for a much longer period — in some instances for as long as 5 hours. When there is no contraindication this latter course is often to be preferred, its purpose being to achieve both maximum descent and maximum molding before delivery is attempted. As greater descent occurs the head has better adapted itself for passage through a restricted diameter: as further molding occurs the head becomes more nearly cylindrical, thus enhancing the ease of rotation and diminishing the likihood of injury to the falx or tentorium. In a desultory 2nd stage, if one does elect to disregard the 2-hour rule he should be ever mindful of the dangers noted above, and prepared to intervene if the character of the labor changes

or as soon as optimum molding and descent have occurred.

*Delivery Face-to-Pubes, without Prior Rotation.* In certain cases delivery as a posterior is to be preferred to rotation prior to delivery. These include especially the cases where the head is upon the pelvic floor, where the sacrum is far posterior, and where the subpubic arch and transverse of the outlet are wide. In this instance one's decision to deliver as a posterior would be strengthened by the presence of very prominent spines which would require elevation high into the inlet before rotation could be safely accomplished. If delivery as an OP is elected, a wide medio-lateral episiotomy is required as the head is already flexed to its maximum and cannot stem under the pubes as does the extending anterior head. If there is doubt as to the pelvic capacity at the outlet it is often desirable to make a cephalic application of the forceps (the concavity of the pelvic curve looking upward) and make a gentle trial traction to determine whether descent can be readily effected. If so, one may continue; if not one may proceed directly to forceps rotation.

*Rotation of the Occiput to the Anterior.* This may be accomplished either manually or by the use of forceps. In either instance, one should remember that the success of the procedure demands that it be carried out with the utmost gentleness and in the most deliberate manner. As for any other intrauterine manipulation, anything less than deep ether anesthesia is unsatisfactory and increases both the danger and the difficulty of the procedure. An assistant should be available to make pressure upon the anterior shoulder at the proper time. If manual rotation can be accomplished easily and without trauma it may be done, and one then proceeds as in a low mid-forceps extraction. In the hands of many operators manual rotation is not universally applicable, and forceps rotation is preferred. Many technics have been described for forceps rotation of the occiput posterior. The Stillman technic which is here described is a modification of that which was originally outlined by Bill[2]; it differs from Bill's technic in that it is not conducted with a single sweeping movement but rather is accomplished by a series of short rotations through a short arc, each of which gently lifts the head from the point of obstruction, rotates without force through this short arc, lifts again, and so on until the rotation is complete. In the hands of many, the sweeping movement advocated in most forceps rotations requires a force which may prevent one from perceiving minor degrees of obstruction, as that caused by a cord tightly around the neck or a bony prominence which impinges upon the head. By rotating without force through a short arc such obstacles are instantly perceived, and the procedure may be altered before damage is done. The intermittent elevation of the head is necessary for when one rotates without force the head is seen to advance slightly at the same time; elevation of the head at the conclusion of each short arc avoids the spiral extraction which is so frequently lethal to the baby. The details of the Stillman technic are as follows: Classical forceps (the Tucker-McLane instrument is preferable) are accurately applied to the head, the concavity of the pelvic curve looking upward just as though the position were anterior to begin with. By making gentle upward pressure in the axis of the birth canal the head can be felt to rise gradually off the point of obstruction. When the head has been lifted away from this point of obstruction and elevated to the lowest satisfactory diameter for rotation, one proceeds to the rotation itself. Throughout the rotation one must mentally visualize the position of the tips of the blades, and by causing the handles to describe a wide arc the flat surfaces of the blades will remain parallel to their original axis. When the head has been elevated sufficiently the handles of the blades are lifted slightly to the anterior, and rotation gently accomplished through an arc of from 5 to 15 degrees. As the head rotates it will be seen to advance slightly; when it reaches its original level or meets any obstruction it is again elevated to the optimum diameter for rotation, and the procedure so continued intermittently until the occiput reaches the anterior. During the rotation the left index finger is kept upon the scalp to note any tendency of the head to slip within the forceps, and the assistant gradually rotates the anterior shoulder across the abdomen. The fetal heart should be checked throughout this procedure. The direction for rotation is generally to the side from which the head has begun its descent, but if any obstruction or difficulty is encountered which is not

overcome by slight further elevation the opposite side should be tried. It is emphasized that these procedures should be carried out slowly, with the utmost gentleness, and with full realization that if any real difficulty is encountered either the procedure is not being carried out properly or one's diagnosis is in error.

When the rotation is complete the handles of the blades are pointing almost perpendicular to the floor. Gentle downward traction is now made to "fix" the head in its new position, and the *left* blade of the forceps is removed from the right side of the baby's head. This is immediately replaced by the *right* blade of the instrument which will be used to complete the delivery; the right blade of the rotating forceps is then replaced by the left blade of the second forceps. The position of the handles is then reversed so the instrument can be locked, and the delivery now completed as in a low mid-forceps operation, gently, and with intermittent traction.

It may be mentioned in passing that this procedure is sometimes useful in the case of transverse arrest where rotation to the anterior is indicated and cannot be readily accomplished. In these cases the occiput is often very easily rotated manually to the direct posterior, and if so one may complete the delivery by the Stillman maneuver. This procedure is considered preferable to the use of either the Barton or Kielland forceps in this particular instance.

*Version and Extraction.* This operation is rarely required in dealing with persistent posterior, but it should be kept in mind and employed without hesitancy when it is needed. It was the operation of choice in 14 of the 443 posteriors reported by W. C. Danforth (3.2%). The indication which is peculiar to the posterior is prolapse of the cord in cases in which the head must be disengaged in order to effect rotation.

SUMMARY

The occiput posterior position is to be considered as a serious obstetric complication, and should be approached with due respect. The influence of the pelvis in the etiology of this condition is briefly considered, the essential feature of which is the observation that the occiput generally tends to rotate to the most ample portion of the pelvis. Careful clinical examination should often enable one not only to predict the posterior mechanism, but also to determine the precise method of delivery which is applicable in that particular pelvis. The most common manifestation of dysfunction in the first stage in OP is uterine inertia with its attendant cervical dystocia. The indications for and limitations of intervention in the first stage of labor are discussed. Operative interference in the second stage of labor is discussed with reference to indications and types of precedure available. The technic of Stillman's procedure for forceps rotation is outlined.

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# INDICATIONS FOR ANTIBIOTICS (PENICILLIN AND STREPTOMYCIN) IN URINARY TRACT INFECTIONS

Russell D. Herrold, M.D.

CHICAGO

In any discussion of the indications for the use of antibiotics,* consideration must be given also to the limitations in the use of these drugs. There are certain general principles that must always be kept in mind. Many species of bacteria already have been classified into one of two groups, susceptible or resistant, and at the present time these groups are fairly well established. For instance, penicillin is ineffective in infections due to gram negative bacilli. In the presence of a susceptible group, the antibiotics must be given in sufficiently high concentration to maintain a constant bactericidal effect, and the duration of such level must be sufficient to assure eventual bacteriologic cure. Nevertheless, there is some degree of deviation of various strains in an otherwise relatively susceptible species.

The treatment of patients with infections of the urinary tract by administration of the antibiotics would be facilitated if it could be predicted on a basis of in vitro tests whether the

From the Department of Urology, College of Medicine, University of Illinois.

Read before the Joint Session of the Illinois State Medical Society, May 15, 1946, in Chicago.

*The streptomycin was furnished through the courtesy of Merck and Company, and the penicillin through the courtesy of Abbott Laboratories.

infection would be likely to respond to this type of therapy. Such information might aid, also, in the determination of the dosage schedule and the necessary duration of therapy. In order to estimate these factors, I have made laboratory observations on the susceptibility to penicillin of infected prostatic secretions, and on the susceptibility to streptomycin of infected urines from patients with disease of the bladder and of the upper urinary tract. Tests of this nature are of significance in relation to the increasing use of the antibiotics.

Since it is accepted that penicillin has to be administered at relatively frequent intervals, day and night, the oral form makes possible its use in ambulatory patients. When its cost is reduced further, the drug will be within the means of the average patient.

*Method Of Testing Susceptibility* — The medium chosen for the tests was Bacto-Proteose No. 3 Agar enriched with Bacto-Hemoglobin. I have used this as an all-purpose medium for the isolation of various bacteria of the urinary tract. It has been used widely for the growth of the gonococcus and has proved satisfactory in the diagnosis and determination of cure of gonococcal infections. Generally, Streptococcus viridans produces a greening on this medium. Although hemolytic streptococci cannot be identified grossly, they occur rarely in the urinary tract. While most gram-negative bacilli found in the urinary tract grow satisfactorily on plain agar, they are frequently associated with other bacteria for which enrichment is required. For use in the clinical laboratory, solid media are preferable, since preliminary identification of the bacteria is more easily and more quickly made. It is important, also, to determine the relative numbers of colonies and whether there are one or more groups in the infected exudates.

A double strength Bacto-Proteose No. 3 Agar was prepared. The penicillin was added to a 2 per cent solution of Bacto-Hemoglobin at a temperature between 45 and 50 C. When the agar, after melting, had cooled to a like temperature, the mixtures were combined and the plates poured. The concentrations of penicillin in this preparation varied from 5 units to 1/100 of a unit per cubic centimeter. The medium was poured in a quantity of approximately 25 cc. to each Petri dish. Such deep plates permit storage for a longer time in the refrigerator without drying. To prevent drying, the plates were wrapped in paper towels. There has not been any loss of potency of the penicillin plates during periods of seven to ten days in the refrigerator.

The penicillin and the control plates were inoculated with the prostatic secretions. By the use of the actual secretions rather than suspensions of bacteria isolated from infected prostates, in vitro studies are more comparable to the in vivo bactericidal effects of the drug when administered to the patient. The numbers of bacteria encountered by the antibiotic would be approximately the same in the laboratory tests as in the patient. The drug would also encounter the bacteria in the same menstrum in both instances. A relatively large loop (5 mm. in diameter) was used for the inoculation, and I have found it satisfactory to put four such inoculums on each penicillin and control plate. Inoculation should be made reasonably promptly after collection. If this cannot be done the specimens should be kept in the refrigerator until used.

*Tests Of Prostatic Secretions.* — The flora encountered in cultures made from prostatic secretions follow similar patterns. Almost all infected secretions have Staphylococci which may be mixed with diphtheroids or other gram-positive bacilli, streptococci, greening or anhemolytic, but generally with only one of the latter four. Staphylococcus albus is the species most commonly found in pure culture, although occasionally Staphylococcus aureus may occur in pure culture. A pure culture of one of the other groups of bacteria may appear also. It is noteworthy that the coliform group and other gram-negative bacilli are seldom encountered in chronic prostatitis, except where this infection is associated with disease of the bladder or of the upper urinary tract. Cultures generally yield like flora on repeated examination in the presence of infection, and the saprophytic flora of the anterior urethra are generally supplanted by the pathogens. In patients without infection, some bacteria are usually found on culture since the urethra is not treated with antiseptics before collection of the specimen. However, the anterior urethra is flushed by voiding of urine just prior to collection of the pros-

tatic secretion. In the final analysis, diagnosis of infection is based on the presence of pus in the expressed exudate.

It would seem from the tests made in this study that 1/10 and 1/50 of a unit of penicillin per cubic centimeter of medium are the optimum concentrations for predicting the relative susceptibility to penicillin of bacteria in infected prostatic secretions. Rarely was there complete inhibition of growth when 1/100 of a unit of penicillin per cubic centimeter was incorporated into the medium. Using 1/10 of a unit for each cubic centimeter of medium, the degree of susceptibility has been found to vary from complete inhibition to no inhibition of growth. On the basis of tests of prostatic secretions from 73 patients, using a dilution of 1/10 unit of penicillin, the results have been classified into three groups as follow: susceptible, 34; intermediate, 23; and resistant, 16. If there was complete inhibition of growth, they were grouped as susceptible, and if there was no inhibition of growth, they were grouped as resistant. The classification, intermediate, included instances of partial inhibition of growth of one or more groups of bacteria or complete inhibition of one group and no inhibition of another. Those patients whose prostatic exudates were found to be susceptible to 1/10 unit of penicillin, listed in the foregoing classification, were tested further in a similar manner except that 1/50 of a unit of penicillin per cubic centimeter was included in the medium. These tests, classified similarly, resulted as follows: susceptible, 14; intermediate, 12; resistant, 7.

On the basis of the in vitro tests which have been described, it can be seen that there is a wide range of susceptibility to penicillin of the bacterial flora of prostatic exudates from patients with chronic prostatitis. At present it would seem logical to select for treatment with penicillin those patients whose secretions have proved most susceptible to the drug in vitro and therefore would presumably be most likely to respond to this type of therapy.

*Treatment of Prostatitis.*—On the basis of the results in a few patients with nonspecific chronic prostatitis to whom penicillin has been administered, it appears that the drug will have to be given for a substantial period of time, possibly as long as two weeks.

A very satisfactory result was obtained in a patient to whom the drug was administered as a course of oral penicillin for fourteen days. This patient had prostatitis, pus, grade 3. The secretion became normal within one month after the institution of treatment and is still normal after a follow-up period of five months. The total dosage was 516 tablets (12,900,000 units). For the first five days 5 tablets (125,000 units) were prescribed every two hours day and night. For the remaining nine days, 2 tablets (50,000 units) were prescribed every two hours during the day, and 4 tablets (100,000 units) were prescribed every four hours during the night. It is generally accepted that penicillin should not be administered orally closer to meals than one-half hour before or one and a half hours after. In another patient with chronic prostatitis and cystitis, pus, grade 3, and pyuria, satisfactory results were obtained in that there was complete relief of all symptoms and bacteriologic cure. This patient also has remained normal after a follow-up period of five months. The course lasted twenty-three days, and the total dosage was 720 tablets (18,000,000 units). For the first seven days 4 tablets (100,000 units) were prescribed every two hours day and night. For the remaining sixteen days, 2 tablets (50,000 units) were prescribed every two hours during the day, and 4 tablets (100,000 units) were prescribed every four hours during the night. Three patients to whom oral penicillin was administered for periods from five to seven days were not substantially benefited when given a maximum total of 280 tablets.

During administration of penicillin for chronic prostatitis, massage of the prostate is done preferably every other day and culture of secretions during therapy is made to determine whether sufficient penicillin is circulating through the prostate to produce effective bactericidal action. This serves as an effective control of dosage during the period of oral penicillin therapy.

Many investigators have tested various antacids and enteric coated tablets and capsules for the purpose of protecting the penicillin from gastric acidity. McDermott and his coworkers (Science 103:359 [March 22] 1946) have recently dis-

cussed the two mechanisms for destruction of penicillin in the alimentary tract, the secretion of acid in the stomach and some other agent, presumably bacterial, in the intestine. There is apparently considerable individual variability in absorption of penicillin when it is administered orally. Also, it has been found that there is a decided decrease in absorption of penicillin from the stomach when not empty. It has been proved that the maximum absorption of oral penicillin is not more than one-third of the like amount given by the intramuscular route. Since maximum absorption does not always occur, it would seem preferable to allow a ratio of approximately five times as much of the drug orally as generally accepted for a specific bactericidal purpose when given intramuscularly.

*Bactericidal Action of Blood Following Oral Penicillin.*—Observations have been made to determine the bactericidal effects of penicillin in the blood after oral administration of varied amounts of penicillin, and at various intervals after administration. Blood was drawn in quantity of 10 cc. and added to a tube containing .5 cc. of heparin to prevent coagulation of the whole blood. This was then combined with an equal quantity of double strength Proteose No. 3 Agar at a temperature of approximately 45 C. and the plate poured. These plates were inoculated with infected prostatic secretions and, after incubation for forty-eight hours, were examined to determine the amount of inhibition of growth, if any. Samples of blood drawn from individuals to whom penicillin had not been administered were prepared in the same way and used as controls. In some instances the blood was taken from the individuals before the administration of penicillin to determine if there was any natural bactericidal effects of the serum alone. In most instances the growth on the whole blood was like that on the Bacto-Proteose No. 3 Agar enriched with Bacto-Hemoglobin, demonstrating that so far we have not encountered any significant amount of natural bactericidal substances in the blood before administration of penicillin.

Readings were then made to determine the degree of inhibition of growth of the various bacteria of the prostatic secretions which were inoculated on to these plates. It was demonstrated that the degree of inhibition of the various bacteria by the penicillin in the blood following administration of oral penicillin was of a similar pattern to that obtained where penicillin was directly incorporated into the media as previously described. Since this penicillin-containing whole blood was diluted with an equal quantity of agar, the amount in the plate represented one-half the penicillin actually in the serum. It has been generally found that the amount of the drug in exudates closely approximates that in the serum. In most instances blood drawn two hours after the ingestion of penicillin had slightly more bactericidal effect than blood drawn three hours after the ingestion although the latter partially inhibited growth of the bacteria in some secretions and completely in others.

*Gonococcic Infections.*—The high susceptibility of the gonococcus to penicillin has enabled quite accurate comparisons to be made of the efficacy of various methods of administration. Now that penicillin is more generally available, substantially larger doses are preferable to those originally recommended for gonococcic infections. A higher rate of cure is thus assured and fewer penicillin resistant infections occur. Where the conventional aqueous solution is used, 50,000 units may be administered intramuscularly at hourly intervals, requiring a period of three hours for the entire dosage of 200,000 units. If convenient in ambulatory practice, however, a preferable schedule is that of one hour between the first and second injections with two hour intervals thereafter.

Another method that has proved highly effective is the use of 300,000 units in beeswax in oil, or the same amount plus a priming injection of 100,000 units of an aqueous solution simultaneously. Also, a single injection of 300,000 units in beeswax in oil may be given with adjuvant treatment using oral penicillin between the eighth and twenty-fourth hours after injection on a schedule of 50,000 units every two hours. Such an intensive course, however, is needed only in patients who have previously proved resistant to smaller doses. Another method of delayed absorption of penicillin which has been reported to be followed by favorable results is that using 200,000 units of penicillin in the so-called water-in-oil emulsion. Also, there have been favorable reports on the use of oral peni-

cillin. This method, however, even if effective, has little to recommend it for gonococcic infection since administration by the parenteral route is practicable in office practice, and serves as a better control of the patient.

*Streptomycin.*—Similarly, I have made in vitro tests with streptomycin in various concentrations in Bacto-Proteose No. 3 Agar. Many of the gram negative bacilli encountered in the urinary tract have been found to be sufficiently susceptible to streptomycin to indicate that cure may be obtained by its use with adequate dosage where these bacteria are the infecting agents. However, certain strains of relatively susceptible species may be naturally resistant, and hence it is important to determine, in advance of therapy, whether the infecting strain of bacteria is susceptible in vitro. Moreover, it is well known that streptomycin resistance develops rapidly with sublethal concentrations of the drug both in vitro and in vivo.

Tests were made for susceptibility to streptomycin on more than 50 strains of various gram negative bacilli from the urinary tract. Generally, suspensions of the organisms were made in distilled water for inoculation on to the streptomycin and control plates. It required between 2 and 50 units of streptomycin per cubic centimeter of medium to produce complete inhibition of growth of the bacteria. However, in the majority, there was no growth in concentrations between 5 and 10 units of streptomycin per cubic centimeter of medium. In some instances comparison was made of inoculation of infected urines with inoculation of suspensions of a like bacteria isolated from the same patient. Generally, similar results were noted, but in a few instances slightly more streptomycin was required to completely inhibit growth from urine inoculations than was required for inoculations of suspensions of the bacteria in distilled water. While there is some variation in the laboratory results when massive inoculums of the bacteria are used as compared to small inoculums, this difference is apparently not so striking with the antibiotics as has been noted with the sulfonamides.

In any series of infections of the urinary tract with gram negative bacilli, it will be found that the species with highest incidence is the so-called regular colon bacilli (Escherichia coli) with Acrobacter aerogenes second in frequency. Of the other miscellaneous organisms, Pseudomonas, Proteus and a mucoid Friedlander type are the most important offenders. While gram negative bacilli predominate in most infections of the bladder and upper urinary tract, staphylococci and streptococci do occur quite frequently. In infections with these organisms, at present, penicillin would seem to have preference over streptomycin and, as in chronic prostatitis, should be given for a substantial period of time to assure cure. Where there is a mixture of gram negative bacilli and gram positive cocci in the urine, it may be advantageous to give both penicillin and streptomycin when the latter drug becomes more generally available. Here, at present, penicillin therapy may be combined with sulfonamide therapy in such mixed infections.

The unit of streptomycin is not comparable to the unit of penicillin. For instance, a dilution of 1/10 of a unit of penicillin to 1 cubic centimeter of medium will completely inhibit the growth of many strains of Staphylococcus aureus, whereas a dilution of 1 or more units of streptomycin to 1 cubic centimeter of medium may be required to produce the same bactericidal effect. Staphylococcus aureus is as susceptible to streptomycin as the most sensitive of the gram negative bacilli. Therefore is requires ten times the quantity of streptomycin, on a unit basis, as penicillin to accomplish the same result against this organism.

The oral administration of the current product of streptomycin is not sufficiently absorbed to justify its administration by this route. The intramuscular route is necessary. It is generally recommended that 2,000,000 units be administered each twenty-four hours on a schedule of 250,000 units every three hours and continued for five days — a total of 10,000,000 units. One gram or 1,000,000 units of streptomycin may be dissolved in 10 cc. of a normal saline solution. It would seem likely that infections with bacteria that have proved more resistant in vitro will require administration of streptomycin longer than a period of five days to effect cure. Tests of cure by either microscopic or cultural methods are unreliable until a lapse of one to two weeks after termination of antibiotic therapy.

Streptomycin in the above dosage is secreted in a concentration in the urine far beyond that

needed to kill the most resistant gram negative bacilli. However, a sufficiently high level of streptomycin must be obtained in the blood serum, and therefore in the tissues, to effect cure. The bacteria may be in the deeper tissues of the urinary tract and not accessible to streptomycin in the urine itself. Failures are likely to occur with streptomycin when infection is associated with certain other pathologic conditions of the urinary tract such as calculi and the various causes of obstruction to free drainage. It is generally accepted that the sulfonamides are valueless under these conditions. In the presence of chronic infection, therefore, it is advisable to make a complete examination of the urinary tract before institution of streptomycin therapy. Most of the acute infections with the coliform group of bacteria, including acute cystitis and pyelocystitis in women where the infection in most instances is of the ascending type, respond promptly to a short course of sulfathiazole or sulfadiazine. Streptomycin is not indicated here at present except when the patient is sensitive to these drugs and unable to tolerate them for a sufficient period of time and with adequate dosage. However, streptomycin would be helpful in patients with a single kidney where the sulfonamides must be given with extreme care or where there is a known sulfonamide fastness of the bacteria.

SUMMARY

In vitro tests of susceptibility to penicillin of bacteria in nonspecific prostatitis gave results that could be relatively classified as susceptible, intermediate and resistant.

The flora encountered in prostatic exudates is discussed in relation to therapy with oral penicillin.

A method of laboratory and clinical correlation during therapy is outlined. The bactericidal effect of blood following oral penicillin is demonstrated.

The use of ample dosage of penicillin is stressed to assure a high rate of cure in gonococcal infections regardless of the route chosen for administration.

Tests of various gram negative bacilli from the urinary tract to streptomycin demonstrate a variation that can again be classified as susceptible, intermediate and resistant.

Contraindications to the use of streptomycin is emphasized in the presence of associated pathologic conditions of the urinary tract until such conditions are corrected.

Tests of susceptibility by using exudates or urines enable a prompt grading and, in addition, where mixed infections occur, the relative susceptibility of the various organisms can be determined.

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## VOCATIONAL REHABILITATION IN ILLINOIS

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In Illinois there are approximately one million four hundred thousand chronically ill and disabled persons according to the results of a recent National Health Survey. Of this number it is estimated that fifty-six thousand are vocationally rehabilitable. It is the responsibility of the Illinois Division of Vocational Rehabilitation to help these men and women become productive and secure in remunerative occupations through its program of physical restoration, training, and placement.

Since physicians are in daily contact with eligible persons, all members of the medical profession should be familiar with the Division and its services in order to refer patients and give information to the handicapped. Reimbursement to the doctor is provided by a liberal fee schedule. The doctor may aid the Division in fulfilling its purposes by making examinations of clients referred to them and by carrying out special restorative measures authorized by the Division. This Division seeks to restore the handicapped individual to the best possible physical condition and place him at the highest attainable level of employment.

Vocational rehabilitation is based on the fact that a handicapped person can compete with normal workers in a selected job which is within the worker's physical limitations and compatible with his abilities.

The deaf and hard of hearing, the epileptic, the cardiac, the tuberculous, the blind, the or-

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thopedically crippled, the mentally ill, and others are eligible for service if there is a reasonable possibility that the individual will be able to engage in an occupation after rehabilitation. To make the necessary adjustments to place the handicapped individual in a suitable job the Division provides medical examinations; psychological testing; vocational guidance, medical and psychiatric diagnosis and treatment; surgery and hospitalization; prosthetic devices; training in schools, colleges, and industries; occupational tools, equipment, and licenses; placement in the right job; and post-placement follow-up to see that worker and job are properly matched.

Rehabilitants have found employment in learned professions; as accountants, auditors; farmers, beauticians, barbers, and manicurists; teachers, draftsmen, and laboratory technicians; sales clerks and retail managers; watchmakers and jewelers; stenographers, secretaries, and bookkeepers; truck and bus drivers; auto and aviation mechanics; radio repairmen and shoemakers; and many other occupations.

All clients of the Division have an initial medical examination. The clients may select any physician licensed in Illinois for this examination. A serology text for syphilis and an urinalysis are essential parts of that examination. The report form has been simplified as much as possible to save the doctor's time in making diagnosis and specific recommendations. If the condition of the client indicates the need of a specialist's examination, the Division pays for an examination by a qualified specialist of the cilent's choice. If medical treatment or surgery is necessary to prepare the client for employment the Division reimburses the doctor and the hospital for their services. In order to be eligible for services in physical restoration the individual must show evidence of economic need. (Economic need is not necessary to make the client eligible for vocational guidance and counseling, psychological testing, vocational training or placement service.) This does not mean the patient must be indigent. He may be able to meet normal living requirements, but unable to assume the expense of treatment, surgery or hospitalization. Eligibility for physical restoration further requires that:

1) the disability must be an employment handicap.
2) the disability must be stable or possibly slowly progressive and amenable to treatment within a reasonable length of time
3) the vocational objective of the individual must be consistent with the probable work capacity of the individual after rehabilitation

Under the Division's program of physical restoration the following services are available:

a) surgical, medical care and psychotherapy
b) specialist's care in all fields
c) hospitalization up to 90 days for any one disability
d) physiotherapy and occupational therapy
e) prosthetic devices for loss of limbs and impairments of vision or hearing
f) nursing services
g) medical social work
h) dental restorative procedures
i) drugs and supplies

After the patient is physically ready for employment, he may be trained for a job within his physical limitations and placed in a position compatible with his abilities.

The cost of rehabilitating individuals into employment is readily justified as an actual economic gain. The expenses of rehabilitation are incurred but once, whereas public assistance costs continue year after year. In Illinois it cost approximately $186 last year to rehabilitate an individual, but it cost as much as $500 each year to support a dependent handicapped person. Not only does rehabilitation reduce costs to the public, but in many cases it actually adds a profit in taxes. For example, the Division spent $431 to rehabilitate a man two years ago and last year he paid $650 in income taxes.

War casualties have aroused public interest in the physically and mentally handicapped veteran, but disabled civilians greatly outnumber the veterans. Congress recognized the needs of the disabled shortly after World War I and passed legislation inaugurating a joint state and federal program. In 1920 Illinois accepted the federal law and established the Board of Vocational Education to administer the Division of Vocational Rehabilitation. This program was limited to vocational guidance, training and

placement for those handicapped individuals who were physically ready for employment.

Public Law 113, passed July 6, 1943, authorized the states to provide medical services to reduce or correct physical or mental disorders which constitute vocational handicaps. Under the present law the Federal Government matches the funds which the states appropriate for these cases and pays the administrative costs incurred by the States in operating their programs.

Today the Division of Vocational Rehabilitation is adequately staffed to serve the handicapped of the state. The staff includes specialists in rehabilitation services; service to the blind, the deaf, and the hard of hearing, and the tuberculous; guidance, training, and placement; physical restoration; public education; psychiatry and psychology. In the field of medicine two medical consultants and a psychiatric consultant serve on the staff. Policies are supervised by the Medical Advisory Council of experts in the fields of orthopedic surgery, general surgery, psychiatry, otology, opthalmology, internal medicine, general practice, physical medicine, public health, nursing, medical social work, hospital administration, industrial medicine, dentistry and medical education. The Illinois State Medical Society has approved the Division's plan of medical service and officers of the society are serving on the Medical Advisory Council.

Each county in the state has a district counselor whose duty it is to locate cases and see that the recommended procedures are carried out. If any doctor would like to contact the district counselor in his area or would like further information, he may write to the headquarters office at 700 East Adams Street, Springfield, Illinois.

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Unfortunately we still have no reliable criteria by which we can determine the prognosis of any arrested case of tuberculosis. It seems almost certain that the far advanced active cases first discovered in later life represent exacerbations of previously inactive disease. At present the only solution to this problem seems to be the discovery of inactive disease among apparently healthy people and regular yearly re-examinations of all previously diagnosed cases for the purpose of detecting release as early as possible. Ann'l Rep't, Cattaraugus Co. (N. Y.) Health Dept., 1944.

## HAZARDS IN THE USE OF SEDATIVES: BROMIDE INTOXICATION

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The adjective 'sedative' is defined by Webster as "allaying irritability and irritation, allaying pain." The noun is defined as "a sedative agent or remedy." Most of us think of sedatives in the former usage as allaying irritability and irritation. We use the adjective or the noun in describing medication prescribed chiefly for conditions wherein there is overstimulation of the nervous system. We prescribe medicines of this nature for many acute and chronic conditions.

The use of sedatives for any of the three indications mentioned in the definition dates back even to pre-Hippocratic medicine. Many herbs, home remedies and preparations are on the list. Organic chemistry has provided us with many newer ones of which the barbital preparations are among the most widely used in recent years. Even with all the newer products the alkaline bromides still retain their popularity. They are extensively used, especially where a milder action over a prolonged period is desired.

Sedation or the use of sedatives, even heavy sedation, is indicated and justified where it is essential to quiet an overactive nervous system no matter what the cause. There are hazards in the procedure but these hazards are no more serious than those in any other branch of therapy. They arise from individual idiosyncracy on the part of the patient, overdosage, prolonged use, and/or habit formation, cumulative effect, synergistic action, summation response where medication of a similar nature has previously been taken and self-medication. Some of these hazards apply to all sedatives. Some apply more particularly to one group or another. Federal legislation controls very well indeed the handling of opium and cannabis indica. Many states have restrictive acts on the sale of barbiturates. Bromides can, in Illinois, be purchased over the counter though the Federal labeling requirements do call attention to some of the hazards incident to their use. A recent examination of labels of some of the widely advertised proprie-

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tary nerve sedatives and treatments for epilepsy fails, however, to impress one as emphasizing this factor.

Bromides and bromide compounds are infrequently prescribed now for acute conditions. Quicker acting alkaloids or barbiturates are more generally employed. Some physicians favor bromides for convulsive disorders, though here they are not nearly so much used as formerly with phenobarbital, dilantin sodium and the newer preparation tridione available. The use to which most of us put bromides is for mild sedation in accordance with the definition as allaying irritability and irritation. As such they are of great value. The cardiologist employs them for functional circulatory disorders as well as to lessen the instinctive apprehension associated with dyspnea or organic heart disease. The gastro-enterologist finds them helpful in many stomach and intestinal disturbances. The gynecologist uses them in lessening tension that accompanies many types of female pelvic dysfunction. Those of us whose primary interest is neuropsychiatry prescribe them often in the attempt to lessen apprehension and anxiety while we are trying to make the patient more accessible to constructive psychotherapy. There is no field of medicine or surgery where they are not used. Since as McLean[1] pointed out some years ago 45 per cent of a series of patients coming to a general medical clinic had disorders of a functional nature and an additional 40 per cent had functional elements associated with underlying disease, it is only natural to expect that in general practice bromides find a great deal of usefulness. As Detweiler[2] says, "They deservedly enjoy wide popularity." Barbour and his associates[3] state that before the war bromides were the fifth most commonly prescribed drug in Great Britain and that one of every ten prescriptions studied contained them. They ascribe this partly to fear of and partly to restrictions on barbiturates there. No figures have been seen on the relative frequency of their use in the United States. As indicated previously the equally deserved popularity of barbital compounds might well cut down the relative proportions in a series of prescriptions here.

Bromides are generally prescribed in this country as sodium or potassium bromide, perhaps as triple bromides, sodium, potassium and ammonium, occasionally as pentabromides containing the three bases plus magnesium and strontium or calcium. Whichever metallic salt is used, and whether singly or in mixture, it is the bromide ion of the salt which has the effect of allaying irritability of the nervous system. The action is central. The work of Boshes[4] indicates that it is due to the presence of the ion in the blood stream rather than in the tissues. He found that the actual bromine content of brains of rabbits that had been given bromides to excess was relatively small when the blood had been washed out. It is fairly generally accepted that part of the action if not all is due to replacement of chloride by bromide in the blood stream. Chlorine, bromine, iodine and fluorine make up the halogen group of elements. Patients in whose blood stream large amounts of bromide have been found show a reduction in chloride. The total halide content or amount of halogen elements in the blood remains relatively constant. Millikan and Paul[5] studied 36 patients who were given sodium bromide in varying amounts over long periods of time. They found that the minimum replacement of chloride by bromide in which intoxication was produced was 23 per cent. Boshes (loc cit) states that when one-third of the blood chloride is replaced by bromide intoxication occurs.

Millikan and Paul describe bromide intoxication and psychosis as follows:

"This syndrome (bromide intoxication) is characterized by the appearance of an increased desire to sleep, dulling of the higher mental functions, slurred speech, unsteady gait and ultimately by the clouding of consciousness."

"A toxic delirium (bromide psychosis) x x x x consisted of the signs of bromide intoxication plus delusions, hallucinations and disorientation." They noted that they were not able to produce a bromide psychosis in any patient having a stable personality.

Our experience from the clinical standpoint is in agreement with theirs though it is difficult at times to know where intoxication leaves off and psychosis begins. There are many reasons for this. One obvious one is that most of the patients we see have some underlying neuropsychiatric disorder as well. Another is that except for acute episodes of recent origin many of these individuals may have been under treat-

TABLE 1

Patients with Na Br of more than 75 mgm. per 100 c.c. in blood serum

| | |
|---|---|
| Manic Depressive Psychosis, Manic Phase | 15 |
| Manic Depressive Psychosis, Depressed phase | 11 |
| Psychoneuroses, various types | 11 |
| Psychosis with Cerebral Arteriosclerosis | 6 |
| Dementia Praecox | 5 |
| Involutional Melancholia | 5 |
| Alcoholic Psychoses | |
| Alcoholic Hallucinosis | 3 |
| Delirium Tremens | 1 |
| | 4 |
| Post infectious Psychoses | 3 |
| Psychoses due to drugs, bromides | 2 |
| Senile Psychoses | 2 |
| Without Psychosis, alcoholism | 2 |
| Syphilitic Psychosis | 1 |
| Epileptic Psychosis | 1 |
| Without Psychosis, cardiovascular disease | 1 |
| | 69 |

TABLE 2

Diagnoses of patients with 150 mgm. or more sodium bromide per 100 c.c. blood serum and/or signs of bromide intoxication.

| | |
|---|---|
| Manic Depressive Psychosis, depressed phase | 7 |
| Manic Depressive Psychosis, manic phase | 5 |
| Pychosis with cerebral arteriosclerosis | 5 |
| Involution Melancholia | 4 |
| Psychoneuroses, various types | 4 |
| Psychoses due to drugs, bromides | 2 |
| Various | |
| Alcoholic Hallucinosis, 2; | |
| Dementia Praecox, 2; | |
| Without Psychosis, alcoholism, 1; | |
| Delirium Tremens, 1; | |
| Post infectious, 1; | |
| Cardiac, 1; | |
| Neurosyphilis, 1; | |
| Senile, 1. | 10 |
| | 37 |

ment for associated or functional conditions until the nervous system element of the illness became such as to call for consultation or hospitalization. Many patients in this group have followed self-medication for some time for "nervousness." They may have continued with their self-medication with bromides while concurrently taking another bromide preparation from a doctor. Some types of persons, who like to take medicine, are prone to do this. We have recently had such an experience in an out-patient who developed a reaction practically right under our eyes.

The symptoms of bromide intoxication and psychosis are seen in many other nervous and mental illnesses. The reaction is often engrafted on the underlying disorder. Therefore, the laboratory determination of blood bromide is of great value in differential diagnosis. Several methods are available. Some are more accurate than others. It is worth while knowing what method has been used. It is important, though often overlooked to know whether the reading is expressed in terms of milligrams of sodium bromide or of bromide ion per 100 c.c. of blood serum. Seventy-seven per cent of sodium bromide is bromine. Our earlier experience was with the Wuth-La Motte method. Cases seen during military service and those from the sanatorium records of the past three years have had determinations made with the modified Wuth method using Coleman or Leitz photoelectric colorimeter. It is felt that for clinical purposes these methods are adequate.

There have been 69 out of 862 patients in our sanatorium during the past five years in whose blood serum sodium bromide, determined by the methods mentioned above, has been found to be 75 mgm. per 100 c.c. or more. Other patients with elevated blood bromide were seen during the course of military service but their records are not available. The sanatorium experience gives a figure of eight per cent of admissions showing a significant elevation of bromide reading. It should be said that determinations are not made routinely though the possibility of this type of intoxication is kept in mind. Perhaps if they had been made the percentage would have been higher. The figure corresponds, except for this feature with the report of Wagner and Bunbury[6] who found 7.7 per cent patients showing elevated readings in 1000 consecutive admissions to the Colorado Psychopathic Hospital.

The diagnoses on these 69 patients are shown in Table 1. Thirty-seven of this group showed readings of 150 mgm. per 100 c.c. or over. Their diagnoses are shown in Table 2. It is seen from these diagnoses that a varied group of situations led to prescribing this type of medication. Those patients for whom the need for this kind of sedation was apparently greater, or had taken it longer, or did not handle it as well for reasons

mentioned below were in the main in the categories of affective or mood disorders. Signs of bromide intoxication were sufficient to be added to the diagnosis of 16 of the 37 patients while note of evidence of symptoms or signs to indicate a reason for the determination being made appeared in most of the records of the others. Psychosis due to bromides or bromide psychosis to use Millikan and Paul's terminology was diagnosed in two instances only. Psychotic elements as a result of the drug, considered superimposed on the underlying illness and called intoxication was the principal notation. Sometimes these elements were the more striking features. They can confuse the picture and can account for atypical reactions unless one either keeps the possibility in mind or makes the special laboratory examination routinely.

Most of the reports in the literature state that signs of intoxication appear when bromide expressed as sodium bromide reaches a level of 150 mgm. per 100 c.c. of blood serum. The usual doses of these compounds probably range from 30 to 60 grains a day. As the renal threshold for bromide is higher than for chloride there may be some retention in the blood stream even in low dosage. However, it is not sufficient to reach the level of intoxication if renal function is adequate. It is well known that impaired renal function lowers the tolerance for bromides. Higher bromide threshold, lowered kidney function set the stage for intoxication. This is more apt to develop in older individuals in whom arteriosclerotic changes in renal vessels have appeared as part of the aging process. Furthermore cerebral arteriosclerotic changes are apt to produce the symptoms of irritability and iritation for which bromides are prescribed. These may be of minor degree but they continue by reason of the vascular process. So medication is kept up for some time. These factors, therefore, call for watchfulness in use of bromides in older people. For these reasons we prefer small doses of chloral or phenobarbital for nervous irritability of this type. Anemic individuals make up another group who do not take bromides well. Detweiler (loc cit) calls attention to the possibility of intoxication from the drug in myocardial insufficiency. Employed to lessen the apprehension associated with dyspnea and tied in with the low salt diet commonly ordered, liability of retention in the blood stream is thus increased. Alcoholics are susceptible to bromide intoxication too. Self-medication is frequent with them to lessen the nervous symptoms of overindulgence. The tendency to take too much liquor applies also to taking too much medicine.

One of the effects of bromides associated in the minds of many physicians and also of many patients is the skin rash. It is interesting to note that bromide intoxication is infrequently accompanied by the characteristic acneform eruption. Detweiler reports skin lesions in 25 per cent. Millikan and Paul show 5 of their 36 patients developing it. We do not recall marked skin irritation in many patients with toxic mental symptoms from the drug. It would appear that presence of skin manifestations in a patient taking bromides lessens the likelihood of concurrent intoxication.

The management of bromide intoxication as such as relatively simple: One must remember that the underlying neuropsychiatric or other disorder for which the drug was ordered or taken is still present. Naturally the first thing to do is to stop all medication containing the element. Some sedation is often necessary for control of active symptoms that may be present. We prefer chloral hydrate for most situations though there is also the choice of either the quick acting or slow acting barbital preparations. Each case should be handled individually.

Specific treatment, if such it may be called, is based on reversing the process that brought about the condition, i.e. replacement of the excess bromide by chloride. This would be accomplished in time by stopping the drug, going ahead with usual diet and allowing normal excretion to proceed. Higher threshold for clearance plus any impaired excretion by reason of general condition or lessened renal function might prolong the process unduly. It can be expedited by increasing fluid intake and giving sodium chloride. We have rarely found it necessary to give salt solution parenterally though this is recommended by some. The enteric coated sodium chloride tablets in amounts of 5 to 8 grams daily usually take care of the situation readily if the patient swallows them easily. If not salt in similar amounts in solution is given by nasal feeding. Salty tomato juice or soup is better tolerated than straight salt solution. Duodenal intubation often helps for if fairly large amounts

of bromides have been taken over a long time gastric irritation is often present. That is why we prefer the enteric coated tablets for oral use. Even after the blood readings have fallen below the so-called toxic level of 150 mgm. per 100 c.c. of serum as a result of therapy some symptoms and signs may persist. Here again the differentiation between those due to bromide and those due to the underlying illness must be made as a guide to further management.

Bromide intoxication is rarely fatal. A survey of some recent literature shows only one death attributed to it. It can be, however, a confusing and disturbing element in diagnosis, course and treatment of many illnesses. Injury can result to patients who fall because of unsteadiness and incoordination. If the possibilities of its arising are kept in mind, if some of the factors that predispose to its development are considered, the likelihood of its occurrence will be lessened. If it does appear it can be pretty well diagnosed by clinical means, confirmed by laboratory methods and treated by simple procedures. It was thought worth while to invite your attention to these features, hence this paper.

The Norbury Sanatorium.

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What are the essentials of a program for the eradication of tuberculosis? First, a medical profession interested in the problem and familiar with modern methods of diagnosis and treatment. Next, complete diagnostic x-ray and laboratory facilities freely available to all physicians in a community and to the health department, regardless of the patient's ability to pay. Third, and equally important, a well-organized active health department with complete family records of all cases and a public health nursing service capable of teaching preventive measures in the home and maintaining effective contact between patient, doctor, and health department. The Modern Attack on Tuberculosis, Henry D. Chadwick, M.D. and Alton S. Pope, M.D. Commonwealth Fund, 1946.

# NEWER ASPECTS IN THE TREATMENT OF LIVER DISEASES

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During the past few years many of the intricacies and complexities of liver physiology have at least been partially solved. With this new enlightenment, it is only natural that newer and more physiologic methods of therapy should have evolved. Experimental data have thrown new light on the relationship of diet, vitamines, and toxic substances to degenerative hepatic processes. The importance of faulty fat metabolism in the liver as a precursor of certain forms of cirrhosis has been justly emphasized. In addition, a great deal has been learned about certain substances which possess a definite protective value and possibly some curative value in liver diseases which are characterized by abnormal fat metabolism. These substances have been designated as lipotropic and in general have been found to be associated with lecithin. Faulty absorption, storage, and metabolism of vitamines in liver pathology are being investigated and the knowledge so obtained is being applied in practical therapeutics. The intimate relationship of the liver to the maintenance of normal levels of serum protein, to the accomplishment of the normal blood clotting process, to the mechanisms of jaundice and to the production of ascites is gradually being more clearly defined.

Since the basic pathology of hepatic disease, whether it be caused by hepatotoxic substances, biliary obstruction, infection, or dietary deficiencies, is fatty infiltration or fatty metamorphosis, treatment should be directed at its prevention. Animal experimentation has contributed much to an understanding of the mechanism of these fatty changes. Thus it has been repeatedly demonstrated that a high fat diet together with alcohol, or a high fat and low protein diet without alcohol, will produce fatty metamorphosis. Similarly, high fat low protein diets which are deficient in Vitamine B Complex, or choline will lead to fatty livers and ultimate cirrhosis. In studying these diets, four factors stand out as probably related in some way to the faulty fat metabolism and cirrhosis. These

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are — first, high fat diet; second, low protein diet; third, deficiency in vitamine B complex; and fourth, choline deficiency. If these factors bear a causal relationship to degenerative hepatic disease, their opposites, namely, low fat diet, high protein diet, adequate vitamine B complex, and choline can be considered to have a protective influence.

Consequently, the dietary management of liver disease assumes a high priority in medical treatment. Protein must be considered to act as a barrier to fatty infiltration and to facilitate the transport of absorbed fats through the liver into the normal fat depots. It also seems to aid in removal of fat which has already been deposited in the liver. In liver disease, therefore, the diet must be high in protein. Furthermore, the protein should have a high biologic value. All the essential amino-acids together with those which the body is unable to synthesize must be included. Proteins rich in lipotropic substances such as choline, methionine, and cysteine are to be preferred. Since meat extractives are known to have a deleterious effect on the diseased liver, the protein should, in so far as possible, be derived from other sources. Lean meat in small amounts is almost essential if all the required amino-acids are to be obtained. Vegetable protein, egg protein, and milk protein in the form of skimmed milk and cottage cheese should make up the bulk of the protein. When patients are unable to take food, intravenous plasma offers an excellent substitute. During the recent war, a circular letter on the treatment of hepatitis suggested that one unit of plasma be given for each meal which was refused or lost by vomiting. The use of amino-acids either parenterally or by mouth is a valuable addition to protein therapy. Since whole proteins and amino-acids must undergo certain synthetic processes in the liver, blood plasma probably offers protein in the most readily utilizable form. If the liver function is so depressed as to have lost its ability to synthesize proteins from amino-acids, plasma offers the best if not the only means of supplying protein.

In order to decrease available fat for deposition in the liver, the ingestion of fats and fatty foods should be definitely curtailed. Furthermore, patients with liver diseases fail to tolerate fatty foods. Dyspeptic symptoms are almost invariable accompaniments of diets which contain even moderate amounts of fat. In particular, one should eliminate, in so far as possible, animal fat. Cream, butter, and oleomargarine are perhaps best tolerated.

Livers which are well supplied with glycogen are less likely to undergo fatty changes. Conversely, a liver which is the seat of fatty metamorphosis is deficient in glycogen. In order to maintain a normal distribution and utilization of glucose throughout the body, liver glycogen must be maintained. Hypoglycemia in liver disease is an expression of a deficient liver glycogen. The diet should therefore be rich in carbohydrate. Fruits and vegetables must form the main source of carbohydrate. Lactose, honey, jelly, candies, and sweetened juices are valuable adjuncts in building up a high carbohydrate value without too much bulk and roughage. Intravenous use of 10% glucose, by producing a temporary hyperglycemia, probably increases the rate and extent of glycogen formation in the liver.

Liver diseases, then, require a diet high in carbohydrate, moderately high in protein, and low in fat. Carbohydrate intake should be in the neighborhood of 250 to 300 grams. Protein requirements are roughly about 150 grams, and fat should be kept below 80 grams.

Patients with normal livers may be given some preoperative protection by the intravenous use of 10% glucose for a day or two prior to surgery. Where gall bladder surgery is contemplated, the liver should be protected by placing the patient on a high carbohydrate and protein diet for several days. If necessary, parenteral amino-acids and glucose may be used to augment the oral intake. As soon as possible after surgery, the patient should be given protein and carbohydrate. A formula made up in the diet kitchen containing whites of six eggs, 50 grams of casein, 50 grams of lactose, and 50 grams of amino-acids in 500 cc. of skim milk can be made reasonably palatable. Two ounces of this mixture at hourly intervals as soon as the patient can tolerate liquids will do much to maintain his protein intake. Intravenous use of glucose, amino-acids, and plasma can always be resorted to when the occasion demands.

Acute hepatic diseases such as infective hepatitis often present serious feeding problems.

The distinct lack of appetite together with the great tendency to vomit makes it imperative at times to resort to parenteral feedings of glucose and plasma or amino-acids. If vomiting be severe enough, saline must be given to replace the lost chlorides. In less severe cases, the patients can be encouraged to take enough food by mouth. In between meal feedings of meat sandwiches or of a formula similar to the one described make it possible to attain adequate carbohydrate and protein intakes.

In chronic hepatic disease which is approaching or has arrived at the early cirrhotic stage, adequate diets can usually be given by mouth. In decompensated cirrhosis, parenteral feedings are often necessary.

Since the discovery of a fat metabolizing hormone in the pancreas known as lipocaic, much energy has been expended in attempts to discover other substances with similar properties. These substances are said to be lipotropic because they tend to prevent absorbed fats from being deposited in the liver. So far, the principle lipotropic substances are choline, methionine, inosital, and certain lecithin derivatives. It is possible that choline is the active agent in all of these substances. Methionine is a precursor of choline, and lecithin is a complex lipid which may contain choline in its molecule. Many proteins contain choline. Casein is rich in methionine, which in turn yields choline, and crude liver extract is known to contain it. Experimentally, diets deficient in choline can produce fatty changes in the liver. Therefore, these lipotropic substances, of which choline seems to be the active principle, can be said to have a protective effect on the liver. Since the prevention and treatment of liver diseases depend largely on preventing or removing fat deposition, it is only natural that choline has been advocated in liver therapy. The salt choline chloride has been employed in doses which vary from 2 to 6 grams daily, given in divided doses. In long standing cirrhosis, where fatty infiltration has given way to fibrosis, choline can be of no value. Variable results have been reported in acute hepatis, but in general it can be said that the results have not been good. Its most promising effects have been demonstrated in cirrhosis of the liver, where fatty changes still make up a major portion of the pathology. Toxic manifestations of the drug resemble those produced by muscarine. There may be cardiac slowing, hyperperistalsis, increased lacrimation, and augmented secretion of other glands. Methionine, since it probably depends on choline for its activity, would seem to have no advantages. Because casein and milk contain fairly large amounts of methionine, they should be strongly emphasized in the dietary management.

Liver disease, although not always associated with obvious vitamine deficiencies, certainly predisposes to such a state. The mechanisms by which these deficiencies are brought about include faulty absorption, defective storage, or metabolic failure. Diets which are deficient in vitamine B complex can produce fatty liver changes in the experimental animal. This complex, therefore, may be considered to have a protective effect on the liver. Since the storage depot for vitamine B complex is the liver, it can be readily realized that hepatic disease may produce variable degrees of depletion. The body is robbed of its reserve and fatty changes in the liver are accelerated. To overcome this handicap, vitamine B complex should be administered in liberal quantities.

Provitaminc A or carotene, being fat soluble, has its absorption interfered with in obstructive jaundice. With severe hepatic damage, the provitamine or carotene, which in the normal liver is changed to vitamnie A, may fail in part at least to undergo this metabolic alteration. Inasmuch as the provitamine is inactive, a Vitamine A deficiency may result unless liberal quantities of the active vitamine are supplied.

Vitamine $B_1$ or thiamine, after absorption from the gastro intestinal tract, passes through the liver where it is phosphorylated and stored as diphospho-thiamine. Thiamine itself is inactive and therefore in severely damaged livers where phosphorylation is impaired, much of the ingested thiamine must remain inactive. Fortunately, other organs of the body possess the ability to activate the circulating thiamine. This active diphospho-thiamine acts as a cocarboxylase and is essential in the metabolism of carbohydrates at the pyruvic acid stage. Since in liver disease, the liver has lost some of its ability to activate and store thiamine, it must be sup-

plied in adequate amounts so that other tissues may compensate for the liver failure.

Vitamine C and D are normally stored in the liver. In liver disease these storage depots may be seriously depleted unless the patient receives an adequate daily supply.

Vitamine K holds a key position in the production of prothrombin which is an essential element in the mechanism of blood clotting. Prothrombin is formed in the normal liver only in the presence of vitamine K. Since vitamine K is a fat soluble vitamine, it requires the presence of bile in the gastro-intestinal tract for its absorption. Therefore, in obstructive jaundice it fails to be absorbed and the production of prothrombin is curtailed. The resultant decrease in circulating prothrombin interferes with the clotting mechanism and predisposes to hemorrhage.

Since in extra hepatic obstructive jaundice the liver parenchyma is usually not too severely damaged, the situation can be corrected by administering vitamine K parenterally in doses of 1 to 4 mgm. or orally in doses of 5 to 10 mgm. daily. If administered orally some form of bile salts such as bilein must be administered at the same time. Without the bile salts the vitamine will not be absorbed. If, however, there be widespread hepatic parenchymal damage, prothrombin will not be produced in adequate amounts even in the presence of an abundance of vitamine K. Obviously, in such cases no benefit is to be expected from the therapeutic administration of the vitamine. To correct such a situation, it is necessary to supply prothrombin and this can only be accomplished by whole blood transfusions. If one fails to obtain an improvement in the prothrombin time after adequate parenteral dosages of vitamine K, it may be assumed that the liver is at fault and that further administration of vitamine K is useless.

Adequate daily vitamine needs in liver disease should approximate the following values — vitamine A — 15-20,000 USP units, vitamine $B_1$ — 2-3 mgm., vitamine $B_2$ — 3-5 mgm., niacine — 25-30 mgm., vitamin C — 50-100 mgm., and vitamine D — 1500-2000 USP units. These quantities can be readily achieved by employing any one of many polyvitamine capsules. To augment the vitamine B complex, 20 to 30 grams of Brewer's yeast can be given, along with periodic injections of crude liver extract. Where liver damage is severe, thiamin hydrochloride in doses of 5 mgm. may be given intramuscularly at daily intervals. Vitamine K need not be used unless there is jaundice and then only if the jaundice be due to an extra hepatic obstruction or a satisfactory prothrombin response is obtained by a short trial of parenteral injections.

Some time during the course of hepatic disease anemia is likely to be manifest. This may be a simple iron deficient hypochromic anemia or a macrocytic anemia with a leucopenia. The macrocytic anemia differs from pernicious anemia in that it is associated with free hydrochloric acid in the stomach and with the presence of the intrinsic factor of Castle. The interference in the hematopoietic cycle seems to be in the failure of the liver to store or to accomplish some metabolic process on the so called maturation factor which originates in the gastric mucosa. The hypochromic iron deficiency anemia should be treated with some form of iron. Ferrous sulphate in doses of 0.2 to 0.4 grams three times a day will usually suffice. Intramuscular liver extract should be employed in the treatment of the macrocytic anemia. Results are in no way comparable to those obtained in pernicious anemia and are often distinctly disappointing. Folic acid, beginning with a dosage of 100 mg. daily and decreasing to 10 mg. a day, may be tried. When the anemia is very marked, blood transfusions may be necessary.

Hypoproteinemia seems to be an inevitable result of long standing liver disease. Plasma fibrinogen and probably plasma albumin are mainly formed in the liver. Furthermore, the liver seems to act as a reservoir for certain loosely bound protein complexes which can rapidly be converted into serum protein as the demand presents itself. The liver then has a threefold relationship to plasma protein, namely, in its production, in its storage, and its renewal. Hypoproteinemia therefore may result from such prehepatic causes as inadequate diet, from such hepatic causes as failure to synthesize and store it and from such posthepatic causes as hemorrhage, ascites, or edema. The management of

hypoproteinemia, in so far as it can be be accomplished, must rest on providing an adequate protein intake.

Ascites, although usually a late manifestation of chronic liver disease, may appear rather early. Various factors seem to play a part in its production. Hypoproteinemia may be a factor, but certainly many cases of cirrhosis have a hypoproteinemia without ascites. Increased portal pressure must at times play a part. Palli has demonstrated an antidiuretic substance in the urine of patients with cirrhosis and ascites. The degree of ascites seems also to bear a relationship to the quantity of recoverable antidiuretic substance. He postulates that this substance is normally formed in the pituitary and destroyed in the liver. As the liver becomes increasingly damaged it loses its ability to destroy the antidiuretic substance and oliguria results. He thereby places the blame for ascites on the inability of the kidneys to excrete water.

Limitation of fluid to about 2000 cc. a day and a moderate salt restriction would seem to recommend themselves. The judicious use of an intravenous mercurial diuretic such as mercuzanthine in 1 to 2 cc. doses may be worthy of a trial. Three to four grams of ammonium chloride may be given in divided doses for several days prior to the mercurial. Paracentesis should be avoided as long as possible. However, it must be realized that a tense ascites interferes with appetite, food absorption, and intestinal motility, all of which functions are essential to the well being of the cirrhotic patient.

In conclusion, it can be said that the modern treatment of liver disease is directed at preventing and removing fat deposits in the liver. This is accomplished by a dietary means with the aid of certain lipotropic substances. Vitamine deficiencies, the inevitable result of liver disease, are compensated for by the continuous daily usage of polyvitamine therapy.

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## ACCIDENTAL MYIASIS IN AN OSTEOMYELITIS PATIENT WITHIN A WELL-SCREENED HOSPITAL

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Even under careful hospital management it is possible for myiasis to occur among patients. Although in the case here reported no harm was done to the patient, the possibility of a similar occurrence with a more dangerous species of fly makes a review of the case desirable.

CASE HISTORY

G. M., male; age 32; married, two children; formerly a farmer. Had osteomyelitis first at the age of eleven. Has dozens of scars at site of former fistulas resulting from bone abscess and subsequent drainage. Three years previously, had the Orr operation on right tibia, then a year later the left tibia and fibula. Healing resulted in both instances after some eight months.

Had recurrence of infection of upper part of right tibia; extended into knee joint and lower end of femur. Some three years previously had developed diabetes and had been taking 40 units of insulin "U-40", three times daily. Infection spread rapidly through entire tibia and he was carrying a high temperature, and required a daily increase in the amount of insulin. Had relatively low urine sugar and extremely high blood sugar in spite of large doses of insulin.

Another Orr operation on tibia and lower end of femur was done under pentothal sodium intravenous anesthesia, and the same day he was given at four hour intervals, 40,000 units of penicillin for a total of 2 million units. Improvement was noticed at once. The plaster cast was not removed for four weeks. At four week intervals casts were removed, repacked with vaseline gauze, and another cast applied. After the third cast the patient complained of the sensation of "something crawling in the wound at the upper end of the tibia". After a few days at his insistence, the cast was removed and maggots were found in the granulation tissue. It was quite obvious that the fly causing the trouble had crawled under the cast and deposited its eggs under dressings into the involved tissues.

Since the hospital was properly screened and due care to eliminate flies had been exercised, the hospital authorities were mystified as to the source of the infestation until it was recalled that the patient had been permitted to go out into the sun on the open lawn during the month of June. No doubt he was struck at this time, the vile-smelling wound having attracted the female fly.

FLY IDENTIFICATION

Two of the maggots were sent to one of us for examination. One of these third stage larvae

was successfully reared through the pupal stage to the adult. The other was used to obtain larval characteristics. According to M. T. James, specialist on muscoid Diptera at the U. S. National Museum, who checked identification, this species should be known as *Phaenicia sericata* Meigen. This species is much more commonly known under the genus designation *Lucilia*. Frequent references to *Lucilia sericata* Meigen occur in medical and veterinary literature.

### CONCLUSIONS

Although at times maggots of this species have been reported to attack healthy tissue, they are generally considered harmless and it is of interest to note *P. sericata* was used extensively in treatment of osteomyelitis wounds during the era when maggot therapy was in vogue. In this case it was impossible to decide whether or not the flies were either beneficial or harmful. The disagreement over the question of whether these maggots attack living tissue or only necrotic material has been a factor in discontinuing this method of therapy.

The possibility remains that more serious flesh-eating flies such as the screw worm (*Cochliomyia americana*) might also strike patients under similar circumstances. This fly is common in the live stock areas of the Middle and Southwest. The loss occasioned by this fly in animals has been estimated as high as $5,000,000 annually. Live stock breeders are careful to prevent injuries by dehorning, shearing and castration operations during the fly season since this species deposits its eggs only in wounds. Numerous cases of human infestation with this species have been reported in the literature and the high incidence of infestation among domestic animals serves to emphasize how common the fly may be particularly in rural communities.

The only sure means of preventing hospital infestations with such larvae would be to confine all patients with open or covered wounds to tightly screened sun porches.

## RESIGNATION OF JEAN McARTHUR

(*Continued from page* 206)

whole and have been well attended in every instance.

The work of the Educational Committee, Scientific Service Committee and Committee on Post-Graduate Medical Service has been done under the supervision of Jean McArthur aided, of course, by competent committees, and it will be most difficult indeed, to find a competent successor to Jean who can carry on, for this work will be continued as an important function of the Illinois State Medical Society.

The thousands of friends of Jean McArthur in Illinois and elsewhere, will miss her, and wish her the very best of everything in time to come. She has worked over this long period of years for the best interests of those whom she served, and although her resignation was accepted reluctantly, she deserves a rest and the officers, councilors and members of the Illinois State Medical Society are highly grateful for the fine accomplishments of these several committees during the past nineteen years.

# Industrial Health

Committee On Industrial Health — Jos. H. Chivers, Chm., 836 S. Michigan Ave., Chicago 5, Frank P. Hammond, H. A. Vonachen, R. I. Barickman, C. O. Sappington, Milton H. Kronenberg.

*Physicians who are interested in establishing a medical program for industry should have a clear understanding of the origin, scope and limitations of industrial practice. The author of the following article who is chief physician of a large manufacturing firm discusses the basic elements of a modern medical program and shows how its effectiveness can be measured. Particular attention is directed to the industrial relations aspects of the medical program and to problems of medical ethics.*

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## ESTABLISHING A MODERN PLANT MEDICAL PROGRAM

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How often does management insure its workmen's compensation liability with a carrier, pay its premiums, and accept the cost entailed as inevitable? The premium payments are based on the hazards each particular industry presents and on past compensation cost experience. If these monies were handled by one of the departments in the plant, management would continually seek ways of reducing such expenditures—yet at least 80 per cent of present-day companies seem completely resigned to the truly "pathetic waste of money" paid out by them in compensation. Workmen's compensation laws logically suggest a medical program in every industry, and if there is no medical program, or an inefficient one, then "pathetic waste" will inevitably follow.

Management's responsibility to its employees changed drastically when the states set up workmen's compensations laws. Prior to that time a company was not responsible for an injury sustained by an employee at work, unless he could prove in a court of law that management's negligence was a contributing factor in his injury. Now, under the workmen's compensation law, whether management's negligence contributed to his injury or not, it must furnish him with adequate medical treatment, even hospitalization and surgery if necessary; it must pay a stipulated portion of his wages weekly if he loses time, and it must pay a scheduled sum if he sustains permanent disability from his injury. In fact, the results of any accident "arising out of and in the course of his work" are the employer's direct legal responsibility. Many of the states include certain occupational diseases arising out of the work; a few States include "any and all occupational diseases." All these developments have taken place since 1910. The enactment of workmen's compensation laws and their administration are state functions, hence the several States have varied degrees of coverage. Compensation laws were originally enacted for the benefit of both the employer and the employee—*i.e,* to protect the employer from ruinous law suits and the employee from the financial loss arising out of an injury at work. Subsequent broadening coverage and more liberal interpre-

tations of the laws have increased the employees' protection and have thus increased the cost to the employer.

The wish to reduce compensation expenditures does not in any way stem from a desire to deprive an injured employee of his just deserts. The wasteful costs are the result of infections and other complications, of excessive loss of time because of the absence of a rehabilitation program, of payments of spurious claims, and many other causes.

When an employee appears at a compensation hearing and swears that his condition was nonexistent before he was hired, the Compensation Commission will accept his word unless it can be proved false. How can the employer hope to refute fraudulent claims unless he has had his employees examined before hire? The saving in proving one preexisting hernia case, for instance, will probably pay for over one hundred preemployment examinations.

When an employee is injured and management simply tells him to "go see his family doctor" he may neglect to do so, thus inviting infection or other complication. He may go to a general practitioner whose experience in industrial medicine and traumatic surgery is decidedly limited. Since the employer must pay for the prolonged convalescence and the poor end-result, is it not more logical to provide immediate and adequate medical care?

When the compensation laws make the employer liable for an occupational disease contracted from an exposure in the plant, management is inviting further waste of money when it permits such toxic exposures to continue. Is it not more intelligent to set up a simple industrial hygiene program to minimize illness and injury arising from work?

The present broadening coverage of compensation laws and their increasingly liberal interpretation makes the need for a medical program now even more urgent. Will management continue to accept as inveitable the wasteful expenditures in compensation costs that a medical program can reduce?

### SCOPE OF THE MODERN MEDICAL PROGRAM

The basic elements of a modern medical program are preemployment examinations, facilities for the care of the injured employee, periodic examinations and an industrial hygiene program.

The preemployment examination lays the groundwork for an industrial medical program. It initiates the employee's plant medical record; it rules out those with contagious disease or with certain specific conditions that will render them unfit for factory work. It permits accurate placement on a job commensurate with the applicant's physical abilities. It lists preexisting conditions to refute subsequent fraudulent claims, and it discloses remedial defects, treatment of which will improve the health of the worker.

In a small industry placement must be accomplished by one who knows the physical demands of each job. In a large industry this can only be accomplished by an analysis of each job to include its physical demands and working environment. The United States Employment Service has drawn up very satisfactory forms to facilitate such job analysis, and their fundamentals have been widely used in industry during the war. With such a job analysis and a parallel physical capacities appraisal by the examining physician, an employment interviewer can place with considerable accuracy the new employee in a job that fits his limitations.

When such a preemployment examination is undertaken it must be thorough for obvious reasons. A recording in some detail of existing disabilities is absolutely necessary in compensation liability since systems or parts not examined are considered negative and hence free of preexisting conditions by the compensation court. Moreover, the employer cannot assure safe employment of the applicant unless *all* of his defects are known. A routine urinalysis and blood Wasserman test should be part of the examination. A chest x-ray should be included if facilities permit or if the industry entails specific dust hazards. Even listing of ranges of motion in previously injured fingers or other joints is of value in apportioning disability if the applicant sustains further injury in the course of his employment.

### STAFFING AND EQUIPPING THE MEDICAL DEPARTMENT

The second basic element of a medical program is the care of the injured employee. Ideally, all necessary facilities should be included in the medical unit. However, this must necessarily vary according to the size of the plant. A plant

of 250 employees must limit its equipment to the simple essentials, whereas a plant of 3,000 or over can benefit by the purchase of several physiotherapy modalities, an x-ray unit, and other types of equipment. It is simple mathematics to prove that a sizable plant will save money by the purchase of an x-ray unit since the cost of x-ray of from $5 to $15 per case can thus be reduced to $1.50 to $2. The number of patients x-rayed will, of course, determine the saving involved. When an x-ray unit is on hand, more cases are x-rayed because the equipment is readily available. Thus fewer fractures are overlooked and improperly treated, and further saving through better medical care is a direct result. Similarly, the purchase of an inexpensive infra-red lamp will save manpower hours and medical expense, even though the volume of cases requiring it may be relatively small. The size and extent of the medical department is dependent upon the plant population and the type of industry. It has usually been found that the basic fundamentals of a medical unit will require expansion within a year after the program is begun, as employees come to recognize its availability and its value to them.

In general, one can estimate that 500 employees will keep one nurse busy full-time and 2,000 to 3,000 employees will keep one doctor busy full-time. Individual requirements can, of course, be scaled up or down from this base.

For the smaller plants a working rule of thumb is as follows: A doctor will be kept busy three hours per week per hundred employees and a nurse nine hours per week per hundred employees. Over-all costs have been estimated at $13 to $17 per employee per year for a medical program. Where size requires three nurses or a multiple of this, two nurses and a clerk will generally function equally well with less salary expenditure, since an industrial nurse spends over one-third of her time in record-keeping.

It is of utmost importance in plants of smaller size to make certain that the nurse is acting under the direct supervision of a licensed physician. An industrial nurse has no license to practice medicine: however, she can minister to the employees according to the signed "standing orders" of the physician to whom she reports.

It should not be necessary to point out that, however extensive and well-equipped the medical unit is, occasionally it will be necessary to engage the services of medical specialists for consultation on individual cases. These should be used without stint where necessary to assure speediest possible recovery and to prevent the occurrance of complications arising from a plant injury. Referrals to specialists depend entirely upon the breadth of training and experience of the industrial physician.

### IMPORTANCE OF PERIODIC CHECKUP

Although the preemployment examination furnishes basic medical knowledge about an employee, there is no assurance of its continued accuracy unless it is followed up with periodic examinations. Such periodic examinations are indicated especially for those employees who are subjected to toxic hazards on their jobs so that it will be possible to detect the earliest indication of toxic effects and remove the man from such exposure. Periodic examinations of the executive force and key personnel are also of particular value. Life insurance statistics have shown that periodic medical examinations actually can prolong the useful life of an employee by 25 per cent. If he is a key person in the organization, the value of repeated health checkups is obvious. Such examinations should be followed by recommendations for correction of remedial defects.

It has been customary in many industries to conduct a yearly physical examination of key employees, an examination of the general plant population once every one or two years, and an examination of those exposed to toxic hazards every three to six months. Where the toxic exposure is particularly great, it may be necessary to conduct examinations at more frequent intervals. A concrete reason for such periodic checkups is evidenced in the following: A large corporation was not convinced that periodic physical examinations would pay for themselves until a robust guard whose blood pressure was normal at the time of hire suddenly had a stroke, due to marked high blood preasure, when he was driving an employee home in the company ambulance. He and the attendant were killed and the patient was badly injured. The total cost of that one accident would pay for several thousand examinations.

### THE INDUSTRIAL HYGIENE PROGRAM

An industrial hygiene program is one of the basic elements of an industrial medical program

that is often overlooked. The foundation for industrial hygiene begins in a plant survey to determine toxic exposures, concentration of fumes and dust hazards, the adequacy of plant sanitation, and other industrial medical liabilities. This survey can be undertaken by the plant medical department if it is sufficiently large and adequately staffed. Many compensation insurance carriers are able to undertake such hygiene surveys; the Mellon Institute will conduct such a survey for member companies; and, of course, such services may be performed by consultants in the field of industrial hygiene.

An industrial hygiene survey brings to light danger points in the plant which may lead to illness or injury, and is aimed at furnishing a basis for specific correction of hazards. Repeated surveys at 6- to 12-month intervals are necessary as production methods change. Such a survey will result in greater cooperation between the medical and safety divisions. The need for this cooperation cannot be over-emphasized, for its absence in one division diminishes the effectiveness of the other.

Health education, an important part of industrial hygiene, is frequently carried on without being labled as such. Every time an employee asks the industrial nurse or physician for advice on medical matters, health education is being given. The effectiveness of pamphlets and talks on health has been questioned by many, but these have been developed to a great degree by some companies. An article on current health problems by the company physician in the plant weekly or monthly paper is a good method of educating employees in health matters.

We have briefly discussed a few of the reasons why compensation laws logically suggest that management set up a medical program and have outlined some of its fundamentals. Now let us consider some of the industrial relations aspects of such a program.

### BENEFITS TO MANAGEMENT, WORKERS, AND UNION

It should be emphasized at the outset that a medical program is a very powerful factor in developing either good or bad industrial relations. At the outset, the program should be supported by publicity indicating that its purpose is the welfare of the employee and the improvement of employee health. This will indeed be its purpose, though it may have been originated through a desire to avoid wasteful expenditures under the articles of the workmen's compensation laws. The healthy employee is of much greater value to management than is the ailing worker and very little added effort beyond that which protects the employer's compensation interests is needed to improve workers' health. It is strongly to be urged that such publicity be utilized when the program is started because at that time, surprisingly enough, the employee often feels that the medical program is to be used against him, to deprive him of a job or of his just recompense under the law.

As the medical department develops, it will furnish a common meeting point between management, the employee, and the union. If the medical department is functioning well, the employee considers it entirely apart from management as such, and looks to its members as a group who have his interests at heart; the union will accept its recommendations and decisions as coming from an impartial group whose prime interest is the physicial and mental welfare of the employee; management will find it an answer to many of its personnel problems.

The employee who is dissatisfied with his job, his supervisor, his shift, or his surroundings often reacts with physical distaste. He considers the job too strenuous or the hours wrong, or the surroundings too dusty, and he approaches the medical department with a request for work change on medical grounds. The industrial physician who is alert to such a reaction always inquires further into the man's mental responses to his job, his supervisor, etc. He can thus uncover situations affecting morale and production and incorporate into his approach the simple applied psychology of the personnel counselor; he can steer the employee to the counselor if the organization has one.

### ENLISTING UNION AND WORKERS SUPPORT

After a medical department is well established it should have gained the full support of the union. The union and the physician both have the same purpose in industry, viz., to work for the good of the employee. Thus the plant physician has a valuable approach to union demands that is denied management. In the begining it is common for the union to come to the medical department and demand justice for the employee.

If the physician's decisions are fair and just, as they must be, he should welcome visits by union representatives to explain to them the reasons for his decisions. It has been found that this results in an understanding by the union representatives that only fair and honest decisions are made by the medical department and their questions will diminish; in fact, they will often defend the decisions of the medical department to the employee. On the other hand, the physician must never make an ill-considered decision and then reverse it under union pressure, for then the employee is led to believe that he will not be fairly treated unless he brings along the union steward for bargaining.

Management often finds personnel problems that have an unexpected medical facet. Consider the employee who had been a good worker, but whose work became so poor that his supervisor was about to discharge him for incompetence. The medical department found that he had a serious condition which adequate treatment by his family physician completely cured and restored him as a valued and useful employee.

Physicians associated with industry frequently tend to develop an attitude of tactless scorn and disbelief—the feeling that all complaints are "gold-brickers"and that it is not worth the effort to display interest in the employee and his progress. No single thing will more seriously affect the employee's opinion of the medical department. His reaction is, "They don't care what happens to me." Nothing will so negate the functions of the medical department, since industrial medicine's effectiveness decreases in proportion to the employees' lack of faith in its adequacy and honesty. The effect is as ruinous as it would be in private practice.

Scarcely any division in the organization can more adversely affect industrial relations than the medical department. The situation became so serious at one large plant that the union refused to sign a contract unless the incumbent medical director was discharged.

Strangely enough, the way he is treated in the medical department indicates to the employee what management thinks of him as an individual. If he is courteously and conscientiously treated, his reactions is, "Gee, management really does care what happens to me." If he is "kicked around" by a disinterested physician or nurse his attitude is, "They don't give a hoot about what happens to me." This reaction is universal and unavoidable in industry. A company that has a tactless, inefficient medical department will never attain ideal industrial relations.

### ELIMINATING WASTEFUL EXPENDITURES

A major difficulty for the industrial physician arises from attempts to reduce compensation costs and still maintain good industrial relations. The only approach to this difficulty is to establish the major premise that the employee will be furnished everything he is reasonably entitled to and that only the pathetic waste of money that comes from poor control of cases and improper handling will be stopped. The employee and his supervisors may not have been adequately taught the need for immediate reporting and treating of all injuries, however trivial. Such neglect may permit infection to develop and can increase the number of permanent disabilities and the total time lost. Wasteful expenditure may be further increased if the industrial physician is inadequately schooled in the proper handling of industrial traumatic cases or is lax in the care of the cases, or not alert to the early recognition of complications.

One of the greatest causes of wasteful compensation expenditures lies in the philosophy that the employee cannot return to work until he is fully able to do his job. Statistics show that the injured worker under the care of a general practitioner is absent from three to five times longer than is the worker who is cared for by the industrial physician. A program for the early return to work of the injured employee will immediately decrease wasteful compensation expenditures as well as conserve valuable manpower. The average employee with simple back strain, for example, will lose two to six weeks work if he must wait until he is able to perform his full job. However, his knowledge and his limited physical ability can be used to good advantage if light work can be found for him during the convalescent period. Aside from stopping compensation payments for lost time, and providing him with his salary instead, such placement prevents him from spending 24 hours a day, over a period of weeks, convincing himself that the company has ruined him for life, that he will never be the same, and that he certainly will never subject himself to such physical

effort again. The employer may never get such a worker back on his old job after he has been given so much time for brooding. In fracture cases convalescence may be prolonged, and placement of the employee in limited work will provide occupational rehabilitation for earlier and more complete restoration of function, resulting in smaller permanent disability awards.

It has been argued that it is cheaper to pay an injured worker compensation than to allow him to return to limited work and pay his salary. This argument is fallacious because during the worker's absence, the company is deprived of all his production effort, though its cost continues. By paying him weekly compensation benefits during a prolonged convalescence, the employer is permitting costly traumatic neuroses to develop and is helping to create higher compensation awards for greater permanent disability. Aside from the loss of valuable production effort, the expenditure in compensation will be reflected in increased compensation premium over a considerable period of time. The establishment of a program which permits temporary light work assignment for injury cases will immediately and considerably affect the company's compensation expenditure.

### MEASURING THE PROGRAM'S EFFECTIVENESS

The best way to determine the adequacy of medical department activities and control of cases is to make statistical analyses of cases and compensation cost trends. Regardless of the size of the medical department, a monthly review of case statistics and compensation expenditures is the only effective device for determining whether or not the department is performing its function. A high incidence of infection cases may disclose the need for earlier reporting of injuries and should stir the physician to concentrate on the medical problems connected with their control. The cost of eye cases may be found to be unduly high, indicating the need for a safety goggle program. A low rate of visits to the medical department may reflect employees' lack of faith in the medical department. Roughly one visit per month to the plant medical facility by each employee is to be expected. Analyses may show a high revisit rate, compared to the number of new injuries listed, pointing to overtreatment of cases or to abuse of medical privileges by employees who visit the medical department for a rest and smoke. Though individual case figures will vary, the average ratio of new injuries to revisits should range between 1 or 1.5 to 1.3. The allocation of a sizable part of the over-all compensation cost to one department or area will suggest the need for a serious study of this area with a view toward installing further safety precautions or providing further safety training for the supervisors and employees in this area. Rising compensation costs with a medical program in effect may suggest a serious revision of the department. Mounting costs arising from hernia cases will point out the need for more thorough preemployment and periodic examinations, and perhaps further installations of hoists on heavier jobs. These and a host of other worthwhile points will arise out of a careful monthly study of case statistics and compensation costs.

### COOPERATING WITH THE INSURANCE CARRIER

In this statistical study the compensation insurance carrier can be of considerable help in pointing out those expenses which are inevitable and those which may be reduced, and in informing management of the ratio between the company's costs and the costs of other similar industries in the area. Close cooperation between the medical department and the compensation insurance carrier is necessary if the company is to provide efficient medical service. Prompt reporting of compensable cases to the carrier by the medical department permits early payment of lost-time benefits and prompt insurance investigation of questionable cases. Misunderstandings easily arise between the medical department and the carrier unless the two work closely. An over-worked medical department may be late in reporting cases, suggesting to the carrier a lack of cooperation. On the other hand, the carrier's recommendation for improvement in the medical activity may be interpreted as interference with industrial medical functions. The tactful suggestions which the carrier may offer for improvement in the medical program should be considered seriously, since the insurance carrier is in a position to see the over-all industrial and compensation picture, can analyze and interpret medical effort in similar industries.

and can evaluate compensation losses in the light of existing compensation bureau practices.

### INDUSTRIAL MEDICAL ETHICS

The problem of medical ethics in industrial medicine has been widely discussed. Industrial physicians have varied in the strictness of their adherence to the rule that medical data is confidential and cannot be disclosed without the patient's permission, since such disclosure leaves the physician open to malpractice suit. Legal advice on this point varies in its interpretation of how far "professional secrecy" applies to industrial medicine. Aside from the question of legality, it is in the interest of good patient-physician relationship in industry to maintain, to some degree, the confidential nature of the employee's medical record. The compensation carrier must necessarily have access to the medical record. Supervisors should not, however, demand detailed knowledge of an employee's condition. The physician will want to explain fully his medical decision concerning an employee to the man's supervisor but he should not, since the details of the patient's ailment should be considered confidential information. However, an indication of the physical status of the employee, such as a weight limitation or other physical capacities appraisal, must be freely given where needed.

In discussions where the employee has invoked the aid of the union, the physician feels freer to disclose more detailed medical data. However, here, too, it is advisable to obtain the express permission of the patient before making such disclosures. The physician may say to the patient: "You understand that to reach a conclusion between management, the union, and yourself, I must apprise them of your condition —since they cannot reach an equitable decision without all of the facts. If you wish me not to discuss your condition here, then they cannot reach a conclusion themselves and must accept my decision in the matter." The employee will then almost invariably free the physician from the obligation to maintain professional secrecy.

A particularly difficult program in industrial medical ethics arises, for example, when a case of syphilis is found in a cafeteria worker. This requires especially tactful handling, and it must be taken up directly with the patient alone. When such a case is disputed by the employee, or union aid is sought by the worker, the backing of the Board of Health is of inestimable value, since it is an impersonal, authorative department of the state.

### INDUSTRIAL MEDICINE AND PUBLIC RELATIONS

The public relations aspects of industrial medicine depend, in part, on the relationships existing among the industrial physician, the general practitioners, and state health agencies in the area. Unfortunately, some degree of animosity had frequently been felt by the general practitioner toward the industrial physician. He felt that the company doctor was taking cases away from him, or was offering medical advice and treatment that he, as family physician, should be giving. This arose partly from lack of mutual understanding and partly from the industrial physician's practice of treating "non-company" conditions. However, this resentment is subsiding now because very few industrial physicians are continuing to treat non-company conditions, but refer these cases to the family doctor. It is further subsiding because the general practitioner is awakening to the fact that industrial medicine represents an enormous case-finding program for him. Many cases that he would not see, or would see too late to effect a cure, are being referred to him now from company health establishments.

Public relations are well served by a good medical program since the reputation of the industry among the population in the area becomes, "They take good care of you in that plant."

### SELECTING THE INDUSTRIAL PHYSICIAN

Obviously the hub of the medical program, whether it be simple or elaborate, is the industrial physician. It is unfortunate that medical schools still do not include the fundamentals of industrial medicine in their curricula and that very few post-graduate courses in this field are offered. For this reason, well-trained industrial physicians still must learn through apprenticeships, or must grow up in the industrial medicine field by trial and error. However, a few good post-graduate courses in this specialty are now being offered.

The most serious mistake one can make in initiating an industrial medical program is to select, as company physician, a young neighboring practitioner who has no interest in industrial medicine and wants the job only until his gen-

eral practice develops to a point where it will support him. It is a mistake to choose a relative of a company executive who is interested only in the added income the job will provide, or to hire an elderly physician who has been unable to develop a satisfactory private practice and who may be well behind modern developments in industrial medicine and surgery. If he can be found, the physician to be selected is the man who has chosen industrial medicine as his specialty, who really has in interest in it, who can see that it is the field of medicine with most promise for pioneering good, and who intends to make it his life's work. Of all of the traits he should have, none is more important than tact and diplomacy. Obviously, he should be a graduate of an accredited school and have a well-rounded background of medicine. He need not be a specialist in surgery or orthopedics or internal medicine—in fact. he will perhaps serve the company best if he is not. He should be expected to have some training in industrial medicine. He should be in good standing in the medical fraternity. Aside from the hearty interest in the development in his specialty, he should have those traits that management seeks in a good organizer and director in any special field.

If the industry is large and is employing a full-time physician, management is in a position to choose carefully, since it can offer good facilities and the type of broad program that will attract the better physician. If the organization is small and in a community of small industries, the company's purposes will best be served through a clinic which pools the medical efforts of several small companies. Where available candidates for the job have not been specifically trained in industrial medicine, management will perhaps be able to judge a doctor's interest in this field by his willingness to spend two to four weeks taking a post-graduate course in industrial medicine.

In conclusion, it should be remembered that the present trend toward broader compensation laws practically demands that management protect its own interests by setting up a medical program. Fundamentally, it is not difficult to do so. In addition to all its other merits, the industrial relations value of the program is incalculable. And, finally, since its success depends in great measure on the competence of its director, management's choice of physician is the key to the effectiveness of a modern industrial medical program.



# Council Meeting Minutes

September 8, 1946
Chicago, Illinois

The regular meeting of the Council was held at the Palmer House, Chicago on Sunday, September 8, with the following present: Berghoff, Neece, Hughes, Cook, Hopkins, Hawkinson, Hedge, Harker, Sweeney, Saunders, Blair, Stevenson, Peairs, English, Lane, Otrich, Hamilton, Coleman, P. R. Blodgett, Hutton, Cross, Jim Leary, Jack Neal, Abraham Levinson, and Camp.

The meeting was called to order by the Chairman at 9:15.

The secretary read his report outlining the work in the office during the summer, and reporting:

There is a new Medical Director at the Regional Office of the Veterans Administration in Chicago with whom we will work under the agreement between the Society and the Veterans Administration.

Told of plans under way whereby before and during this centennial meeting the A.M.A. through the Bureau of Public Health Instruction proposes to dramatize the work of some pioneer physicians, and they have asked for some names of outstanding Illinois men and high lights of their practice, then several of these men would be selected according to established regions, and the dramatizations would be under way. They also wanted the name of a speaker from Illinois capable of speaking over the radio on Medicine of Today.

The A.M.A. House of Delegates will hold a mid-year meeting in Chicago the early part of December. The centennial meeting will be held next June in Atlantic City and plans for national radio programs are being made.

The new committee on Prepayment Care Plans has met; the files have been sorted and placed in the Chicago office; mimeographed forms to be given to the companies interested in participating have been prepared and are in the Monmouth and Chicago offices. Several companies are ready to submit material for approval, and another meeting is planned for the near future.

A letter was received during the past week from the California State Medical Association and enlcosed were resolutions adopted by the American Legion and also by the California State Chamber of Commerce in which compulsory health insurance is opposed. They suggest that efforts be made to secure similar actions in Illinois.

We have received an advance copy of the new book issued by the N.P. entitled, "Compulsion, The Key to Collectivism." Copies have been secured for distribution to all Councilors.

The Chairman ruled that the report of the secretary be received.

Berghoff reported as President of the Society. (1) The conference of State Society Presidents and other officers was held at the A.M.A. meeting in San Francisco. The executive committee of this organization met and reported and it was extremely interesting to note the comprehensive knowledge these men had relative to national issued and situations in the various states. Relative to Illinois, they had knowledge of the work Dr. Coleman, our past-president has done during the past two years, the work of our Educational Committee, and many other of our activities. Thirty-two states were represented, and the Council definitely should make a practice of sending the President to this meeting, and Illinois should be represented when this group meets.

The Illinois Commission on the Chronically Ill is making a survey and assistance should be given this group.

This might be the year that funds could be collected for the Benevolence Fund of the Society. Journal publicity could be given this project. The Chairman, Dr. Lucius Cole, died during the past month. As president of the Society, Berghoff asked Dr. Hawkinson to accept the chairmanship of this Committee until the May meeting of the House of Delegates. Hawkinson accepted this appointment.

MOTION: (Harker-Otrich) that the report be approved and that Berghoff accept the chairmanship in Illinois for the National Memorial Home for Nurses; and that the appointment of Hawkinson as Chairman of the Benevolence Committee be approved. Motion carried.

Neece reported as president-elect stating that he had a short report of comments on the general situation. Harmony among our ranks is one of the essentials at the present time coupled with friends in all walks of life. The spirit of harmony in the society seems to be developing and the present problems we have to

face, prepayment insurance plans and the work for the Veterans Administration, etc., will all work out.

Coleman reported that the I.P.A.C. under Hilliard has been handling the old age assistance aid to dependent children and the blind programs. Now the question of the chronically ill has been presented to them. A commission has been appointed by the state legislature of which Hilliard is secretary. An investigation of the care of the chronically ill in Illinois is being made. Many of those in this classification are recipients of old age pension, and in the past, many have been committed to state institutions for the insane for care. Many portions of the state have a too-low per capita wealth to support institutions for the care of these people, and as a result the state has had to assume this load. There is a willingness in the legislature to accept medical advice, and a committee to work with Hilliard in this survey has been appointed by the president of the society.

Otrich stated that the meeting in St. Louis of the N.P.C. had been instructive and interesting, also that the investigation of the care of the chronically ill is definitely needed in the southern part of the state. The old people are in institutions instead of homes and a program of this kind should meet with support from rural districts.

Hutton reported as Chairman of the Medical Service & Public Relations Committee: "This report is based on an 8-page typewritten report which I had asked Mr. Leary to make for me. His activities have been taken up first by familiarizing himself with the Society and its activities and then by handling the publicity regarding the May meeting and the special meeting of the House of Delegates.

The Council gave the Committee permission to study the advisability of getting out a booklet on Health Education. After some investigation it was decided not to do this and so the project has been abandoned.

Mention was made of the fact that Miss McArthur's position will have to be filled as of September 28. A number of applicants are being considered but no decision has yet been made.

Berghoff: Relative to the Hill-Burton bill which has been passed, the survey of the hospital situation in Illinois has been made and the Governor has turned this matter over to the Department of Public Health. Cross accepted the responsibility and members of this council are members of the working committee and also of the Executive Committee.

John W. Neal reported as executive secretary of the Medical Service and Public Relations Committee. In discussing the question of endorsing various political candidates, a routine is definitely established and there are two or three rules which are always followed. Politics is not considered, and the candidate is endorsed on past record in the legislature; no candidate is endorsed for a first term. In the past, these letters of recommendation have been sent out only for state representatives and congressmen. We should consider endorsing federal candidates.

Unemployment compensation may be broadened to cover sickness insurance and disability, and injury not of an industrial nature. The group this would affect is definitely low income and the accident and health insurance companies will probably not fight the proposal.

James C. Leary, public relations counsel, stated that most of the past activity of his department had been covered in Dr. Hutton's report. He stated that future activity would include additional articles on health subjects, work with newspapers on publicity; furthering the activities of the committee on prepayment health insurance, and tieing his work in with that of John W. Neal.

Hopkins reported as Chairman of the Committee on Voluntary Prepayment Plans. He stated that there was an urgent need to have policies for sale in Illinois. A meeting of the Committee was held on August 13 with the full committee in attendance. In addition to the 12 principles already adopted, four new ones were introduced and made a part of the material to be presented to insurance companies desiring to participate in the program.

MOTION: (Hopkins-Hamilton) that the Council approve the adoption of these four additional principles. Motion carried.

Hopkins: The files are now in the office at 30 North Michigan and can be looked over by anyone so interested. When technicalities are complied with, and the committee has had an opportunity to meet, at least two other companies are ready to enter this field.

The Veterans Service Committee, acting in an advisory capacity to the Veterans Administration, held a meeting with the C.M.S. Veterans Service Committee, the C.M.S. Post-War Planning Committee, the I.S.M.S. Veterans Service Committee, with an excellent representation present. The administrative details of the agreement with the Veterans' Administration were worked out and explained.

Our attention has been called to the fact that our fee schedule is lacking in psychiatric charges, and that the anesthetists are not satisfied with the present listings. If the committee can work this out, they will do so.

The Blue Cross is to act as the liaison division between the Veterans Administration and the Illinois Hospital Association. Member hospitals of this Association may admit veterans under this program, and will be paid the same rate as Blue Cross. Blue Cross pays the account, adds 7½% for administrative work, and is paid by the Veterans Administration.

Dr. Abraham Levinson reported as Chairman of the Committee on Mental Hygiene and the consideration the commitee had given the examination forms submitted by the Department of Public Instructon, Springfield. The committee recommends:

1. The Committee approves the use of the form suggested by the Department of Public Instruction.
2. The majority of the members of the committee believe that $10.00 is the proper amount to pay the physician for examination of the children and for filling out the form.

3. The committee recommends that every one of these children should have in addition to the physical examination, a Wassermann or Kahn test.

The Committee would like to know how far it can go in connection with the problem of mentally handicapped children and also the spastic child, with reference to state institutional care.

MOTION: (English-Hedge) that the Council approve Levinson's report, and authorize the Committee to deal with all phases of mental hygiene activities in Illinois. Motion carried.

Hopkins reported as Chairman of the Journal Committee, and asked Council approval for Malley to go east in September to interview advertising agencies relative to Journal contracts. The expenses in connection with this trip should be paid by the Society.

MOTION: (Hopkins-Neece) so move. Motion carried.

Dr. Blair reported that the Committee on Constitution and By-Laws had met Saturday evening, September 7, to consider the proposed constitution and by-laws of the Interprofessional Council, as directed by the State Society Council at the June meeting. At this meeting Dr. J. R. Blayney was present representing the State Dental Association.

The Constitution was presented to the Council in its entirety.

MOTION: (Blair-Neece) that the Council authorize the adoption of this constitution and by-laws for the Inter-Prorofessional Council. Motion carried.

Cross reported as Director of the Department of Public Health. He stated that he had recommended that Rodney Brandon, as head of the Sister Elizabeth Kenney Fund in Illinois, work through the Division on Services for Crippled Children as a part of the services of the University of Illinois. This work is under the direction of Dr. Kobes, 110 South 6th Street, Springfield.

MOTION: (Hopkins-Hedge) that this recommendation relative to the use of Kenney Foundations Funds be approved by the Council. Motion carried.

Relative to the activities of the Department of Public Health:

1. The establishment of county health departments is progressing nicely. Four counties have voted in favor of setting up health departments and levying a special tax to maintain them. The proposition will be on the ballot in each of 18 additional counties at the general election in November.

2. School health programs have been in progress throughout the state. A program of teacher training in health education has been presented. In 1946 these courses reached several hundred espcially selected teachers from 70 counties and a group of about 100 school administrators.

3. From November, 1942, through June, 1946, the Department, through the E.M.I.C. program, has authorized medical and hospital care to 57,047 pregnant wives and 8,124 infants of men enlisted in the armed forces. A total of $5,282,849 was disbursed for this purpose. Of this amount, $87,750, slightly over 1% represents administrative costs, while 99 percent went directly to 4,889 physicians, 238 hospitals and a few others that provided services.

4. The Department has acquired two mobile x-ray units, and tuberculosis case findings have been greatly increased. Surveys have been made in 21 counties, and a total of 42,889 people have taken advantage of this service. Results are not tabulated, but all individuals with any evidence of chest pathology are referred to physicians of their choice for further observation and diagnosis. Two more units will be acquired in the near future, and the State will construct tuberculosis sanatoria for which two sites have already been selected.

5. Through the cooperation of the Red Cross, plasma has been made available for distribution to physicians and hospitals by the Department. The supply will last approximately another year. Future needs are being considered and the Department is undertaking to develop a plan whereby this service can be continued.

6. Federal funds make $129,000 available for cancer control while $38,610 has come from state sources. The expansion of tumor diagnostic centers, the development of follow-up services, closer cooperation with other agencies are all items on the agenda for this year. During the first six months of 1946, 478 new patients were examined in these centers while 1,651 patients returned for follow-up visits. 1,218 physicians visited these centers to take advantage of the discussions concerning cancer patients.

7. $50,000 is available from federal funds to permit expansion of the industrial program of the Department. This is a service rendered to small industrial organizations requesting such health work and desiring the services.

8. The Hill-Burton bill has been passed by Congress and Illinois is well-equipped to make use of the funds available under this Act. With the aid of the Advisory Council, the Department is devising a master plan with the end in view of providing adequate hospital facilities for all residents of the state. Thus when federal funds are appropriated and allotments made to the various states, Illinois will be well on the way toward completing requirements necessary for participation.

One other item for discussion is the fact that the Department has recommended that no full-time employee of the Department should engage in the private practice of medicine. The Governor's Advisory Committee to the Department has passed a resolution to that effect.

MOTION: (Lane-Blair) that the Council approve the report and resolution. Motion carried.

MOTION: (Hamilton-Neece) that the Council recommend similar action on the part of the Department of Public Welfare. Motion carried.

Harker reported that the Chicago Councilors had met in the office at 30 North Michigan Avenue and would recommend to the Council that H. K. Scatliff be selected as Chairman of the Committee on Arrange-

ments and that R. C. Oldfield be selected as Vice-Chairman.

MOTION: (Harker-Berghoff) that these men be so appointed.

Stevenson: The Council should determine the definite dates for the annual meeting during 1947. Collision of the Palmer House suggests that the meeting be held Monday, Tuesday and Wednesday, May 12, 13, 14, 1947.

Camp: We wrote all technical exhibitors and requested that they state their opinions regarding the change. Very few registered a definite protest, and since the Palmer House has requested the change, it would seem wise to make the decision in favor of the 12, 13, 14, of May.

MOTION (Otrich-Hughes) that the 1947 annual meeting be held May 12, 13, 14, 1947. Motion carried.

Camp: The Women's Auxiliary has requested official action on the part of the Council relative to their proposed annual meeting to be held at the Congress Hotel.

MOTION: (Coleman-Hughes) that official permission be granted the Auxiliary to meet at the Congress Hotel in 1947. Motion carried.

MOTION: (Harker-Hawkinson) that 50-year club membership be extended to C. W. Carter, Clinton. Motion carried.

Camp: It has been suggested by Leary, our Public relations counsel that the surplus copies of the first volume of The History of Medical History in Illinois be distributed to large newspapers, medical libraries, high school libraries, etc., with the compliments of the State Society.

MOTION: (Harker-English) that the books be so distributed, and that a copy be sent to all members of the Council who do not have one already. Motion carried.

Blair: In my opinion the distribution to High School libraries is one of the most important phases of this plan. All high schools have active libraries, and the book is more likely to be read there than elsewhere.

Camp: The 100th anniversary of the founding of the A.M.A. will be celebrated during 1947. The meeting in Atlantic City will climax this celebration, and elaborate plans for the 100th year are being made by the A.M.A. A letter from W. W. Bauer of the Bureau of Health Education outlines some of the plans. Radio programs will be given dealing with a dramatized story of the life of outstanding men in medicine during the last 100 years, and speakers from each section of the country will talk on medicine today.

MOTION: (Hawkinson-Hedge) that the matter be turned over to Dr. Hutton as Chairman of the Medical Service and Public Relations Committee. Motion carried.

Otrich: As far as dramatizing the life of an Illinois physician is concerned, the life of Fisher in Randolph County would make good copy. He was the first speaker in the Illinois legislature.

Camp: The A.M.A. has adopted a ten-point program for medical activities and several state societies have done likewise. This would seem to be one of the functions of the Medical Service and Public Relations Committee and the material should probably be referred to the chairman.

MOTION: (Hedge-English) that this be done, and that the Illinois State Medical Society also develop a ten-point program. Motion carried.

Emeritus membership is requested for:

Herman Schmidt, Okawville, Washington County

J. B. Holmes, Macomb, McDonough County

MOTION: (Hughes-Neece) that these two men be elected to Emeritus Membership in the state society. Motion carried.

Camp stated that the California Legion and the Chamber of Commerce had adopted a resolution against compulsory health insurance. It would seem advantageous to secure if possible, similar action on the part of the component organizations in Illinois.

MOTION: (English-Neece) so move. Motion carried.

MOTION: (Coleman-English) that the bills as audited by the finance committee be approved. Motion carried.

Meeting adjourned.

Respectfully submitted,

Harold M. Camp, M.D., Secretary

F. C. Zimmer

## CORRECTION PLEASE

Correction in minutes of the meeting of the House of Delegates, May 16, 1946 as follows: The nomination of C. O. Lane as Councilor for the Ninth District was made by Dr. H. A. Felts of Marion.

The only weapons of proved and generally accepted value against tuberculosis are discovery, isolation and treatment of all active cases. (Roberts Davies, M.D., G. A. Hedberg, M.D. and Mario Fischer, M.D. Am. Rev. of Tbc., March, 1946.)

# News of the State

## PERSONALS · COMING EVENTS · MARRIAGES · DEATHS

### ADAMS COUNTY

Plans to establish a well babies' clinic were furthered in the meeting of the Inter-Racial Fellowship of the Quincy Council of Churches held in the Community House recently. Miss Charlotte Rickman, health educator, was appointed to confer with the Adams County Medical Society on the project.

### BUREAU COUNTY

Dr. Robert S. Berghoff addressed the Bureau County Medical Society at Princeton on September 10th, subject, "Heart Disease."

### CHAMPAIGN COUNTY

Dr. James J. Callahan was invited to present the scientific program before the Champaign County Medical Society on September 5th. His subject was "Fractures of the Extremities."

### COOK COUNTY

Two Scientific Meetings of unusual interest have been announced by the Chicago Medical Society. On November 20 Dr. W. A. Altmemeier, Professor of Surgery at the University of Cincinnati will give a paper on "The Value and Limitations of Chemotherapy in the Management of Certain Surgical Conditions" and Dr. Chester S. Keefer, Wade Professor of Medicine at Boston University School of Medicine, speaks on "Chemotherapy on the Management of Medical Infections."

The second meeting on December 11 brings Dr. Carl V. Moore, Professor of Medicine, Washington University School of Medicine, St. Louis, with "An Appraisal of Folic Acid for the Treatment of Anemia," and Dr. John D. Stewart, Professor of Surgery, University of Buffalo Medical School on "Hemoptysis."

Both meetings will be held in the John B. Murphy Memorial Auditorium, 50 East Erie Street, beginning at 8:00 P.M.

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The Chicago Roentgen Society will hold meetings on the second Thursday of November, January, February, March and April at the Palmer House at 8:00 P.M. Officers of the society elected at their April meeting are: Doctors Earl E. Barth, President; Fay H. Squire, Vice-president; T. J. Wachowski, Secretary.

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Dr. A. C. Ivy, vice president of the University of Illinois, has announced the appointment of Dr. John Barlow Youmans as dean of the College of Medicine at the University's professional colleges here.

Dr. Youmans' appointment is effective as soon as he can terminate his activities at Vanderbilt University and elsewhere. He has been professor and acting dean of the department of medicine at Vanderbilt.

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Dr. John P. Coughlin talked on "Ready for School" before the Hayt School Parent Teacher Association on September 10th.

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Dr. and Mrs. Channing W. Barrett observed their fiftieth wedding anniversary, July 22nd.

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Dr. Vida Latham addressed the Lake Shore Business and Professional Woman's Club, Chicago, on "Socialized Medicine" during September.

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Dr. Victor M. Towle addressed the Rotary Club in Chicago Heights in September on the subject, "The Physician in General Practice."

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Dr. Irving D. Harris of the Institute for Juvenile Research addressed the Tonti Parent Teacher Association September 17th on "Health and Emotional Problems of Children."

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The Priestley Medal of the American Chemical Society was presented to Roger Adams, Sc.D., professor and head of the department of chemistry, University of Illinois, Urbana. The award goes to Dr. Adams for his distinguished work in organic chemistry.

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Dr. Howard Weatherly talked on "Mental

Health" before the Harriet E. Sayre Parent Teacher Association on October 9th.

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A program on "Legislation of Interest to the Public and the Medical Profession" will be presented on November 12th before the Eberhart Parent Teacher Association by Mr. John W. Neal, executive secretary of the Committee on Medical Service and Public Relations.

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Capt. Clarence E. Quaife, formerly of Galesburg, Illinois, was the recent recipient of the Army Commendation Ribbon for "exceptionally meritorious service" in rendering medical treatment to wounded prisoners of war during a riot at Fort Dix, New Jersey, on June 29, 1945. His exemplary conduct in this difficult and dangerous situation has brought great credit both to himself and to the military service." Dr. Quaife graduated from the University of Louisville School of Medicine in 1943 and entered the service Jan. 13, 1944.

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Dr. Harold A. Greenberg of the Institute for Juvenile Research has been invited to address the Alexander Hamilton Parent Teacher Association November 12th, subject, "Behavior Problems of the Child in Home and School."

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Dr. Andrew C. Ivy, vice president of the University of Illinois, has been named to the reserve consultants' board of the United States navy. During the war, Dr. Ivy was director of the naval medical research institute. Dr. Francis L. Lederer, head of the school's department of otolaryngology, was named consultant in that specialty at the Great Lakes Naval Training station.

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Dr. A. D. M. Kraus will talk on "Shots" before the Stewart Ridge Mothers' Club on November 20th.

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A program on the subject of "Socialized Medicine will be presented November 22nd before the Chatham Fields Woman's club by Dr. Harry A. Olin.

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Dr. Smith Freeman has resigned as professor of physiology at Northwestern University Medical School to become head of the biochemical section of the Mayo Clinic, Rochester, Minnesota and professor on the graduate faculty of the University of Minnesota.

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Doctors Max and Philip Thorek addressed the Seventh Harlow Brooks Memorial Navajo Clinical Conference held at Sage Memorial Hospital, Ganado, Arizona, August 29-31,1946. The former lectured on "Eleven Years' Experience with Electro-Surgical Obliteration of the Gall Bladder Without Drainage" (with motion pictures) 4449 cases. The latter spoke on "Differential Diagnosis of the Acute Abdomen."

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Wendell J. S. Krieg, Ph.D. associate professor of neurology at Northwestern University since 1944, has been appointed director of the Institute of Neurology and professor of neurology, to succeed William F. Windle, Ph.D.

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Dr. James P. Simonds has retired from Northwestern University with the rank of professor of pathology emeritus.

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Dr. Thomas C. Laipply, assistant professor of pathology, Western Reserve University School of Medicine, has been appointed associate professor of pathology at Northwestern University Medical School.

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The appointment of Dr. Sydney P. Waud, a member of the Northwestern University medical school faculty, to the state's Medical Center Commission has been announced. He will replace Dr. Raymond B. Allen, former dean of the University of Illinois. Dr. Waud has returned to civilian life after three and one-half years of army service in India, where he commanded the 20th General Hospital at Assam.

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New officers for the Chicago Society of Allergy are Dr. William A. Mowry, Madison, Wisconsin, President, Dr. Theodore Bernstein, Chicago President-elect and Dr. Edward George Tatge, Evanston, Secretary-Treasurer.

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Dr. M. A. Perlstein will address the Chicago Pediatric Society on November 5th and the Alleghany County Society for Crippled Children in Pittsburgh, Pa., November 16th.

Dr. Edward W. McNamara has been presented with the Meritorious Civilian Service Award. According to the citation accompanying the award, "as an employee relations officer in the Civilian Personnel Division of the Chicago Ordnance District, Ordnance Department, ASF, he has done an outstanding job in bringing about a better working relationship between the Chicago Ordnance District and its civilian employees through increased morale and reduction of absenteeism."

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## DEKALB COUNTY

Dr. E. G. Quattlebaum of Rockford addressed the DeKalb County Medical Society on October 4th, subject, "Illinois Pre-Payment Medical Care Plan."

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## DU PAGE COUNTY

The DuPage County Medical Society had their

fall opening meeting at the Arrow Head Golf Club on September 18th.

### FRANKLIN COUNTY

Dr. William H. Walton of Belleville addressed the Franklin County Medical Society September 26th on the subject of "Undulant Fever."

### GREENE COUNTY

Dr. Emmet F. Pearson, Springfield, addressed the Jersey-Greene County Medical Society, subject, "Malnutrition Observed in Santo Tomas Internment Camp", September 13th.

The Greene County Medical Society voted to cooperate with the American Academy of Pediatrics in the Nation Wide Study of Child Health Services. Dr. Paul Daley was appointed county chairman for this study.

Dr. Earl Walker, formerly of Chicago, has transferred his membership to the Greene County Medical Society.

### JEFFERSON COUNTY

Dr. Herbert E. Schmitz, Chicago, has been invited to address the Southern Illinois Medical Society, on November 14th. His subject will be "Cancer of the Uterus."

### LA SALLE COUNTY

Dr. Donald W. Killinger, Joliet, addressed the Marseilles Woman's Club on October 14th, subject, "Facing the Forties."

Doctors Andrew C. Ivy and Robert Keeton have been invited to present the scientific program before LaSalle County Medical Society in December. Dr. Ivy will discuss "Obesity and Leanness" and Dr. Keeton will talk on "The Problem of Obesity and Leanness."

### McHENRY COUNTY

Dr. Edwin R. Levine addressed the McHenry County Tuberculosis Association at Woodstock in September on "The Tuberculosis Problem."

### McLEAN COUNTY

Dr. Frederick H. Falls presented a scientific program on "The Diagnosis and Treatment of Ectopic Pregnancy" before McLean County Medical Society on September 10th.

### MORGAN COUNTY

A summer institute for mothers of preschool blind children was held at the State School for the Blind, Jacksonville, August 25-30, under the auspices of the state department of public welfare, Illinois Commission for Handicapped Children, University of Illinois division of services for crippled children, and state superintendent of public instruction. Among the speakers were: Dr. George L. Drennan, Jacksonville, "Physical Development of the Child"; Dr. Barbara Spiro, Chicago, "The Structure of the Eye and Causes of Blindness."

### PEORIA COUNTY

The Illinois Welfare Association will have a conference at the Pere Marquette Hotel in Peoria on November 18th. Dr. Robert S. Berghoff will talk on "Hospital Survey."

### STEPHENSON COUNTY

Acting on the recommendation of the Medical Advisory Committee of the Stephenson County Medical Society, the Stephenson County Junior Fair was postponed to October 3, 4 and 5th because of the prevalence of infantile paralysis in the Freeport area.

### UNION COUNTY

Doctors John Hrabik and R. S. Sabine of Murphysboro presented an obstetrical program September 12th. Dr. Hrabik spoke on "The Toxemias of Pregnancy" and Dr. Sabine discussed "The Emergencies in Obstetrics."

### VERMILION COUNTY

Dr. J. J. Moore, Chicago, addressed the Vermilion County Medical Society on October 8th, subject, "Biopsies."

Dr. Harlan English, Danville, has been invited to give a talk on "Socialized Medicine" before the Business and Professional Woman's Club of Chicago on November 18th.

The following scientific programs have been arranged for the Vermilion County Medical Society:

November 5 - Dr. Harry M. Hedge - "Dermatological Conditions as Seen by the General Practitioner"

December 3 - Dr. Louis R. Limarzi - "Diagnosis and Treatment of Common Blood Disorders"

January 7 - Dr. James J. Callahan - "Common Fractures"

The speakers are from Chicago.

### WARREN COUNTY

Dr. Harry A. Warren, Peoria, has been invited to address the Woman's Club of Monmouth on the subject of "Heart Disease" on November 8th.

Dr. George E. Kirby of Spring Valley will address the Woman's Club of Alexis on November 26th, subject, "What WE Are Doing About Cancer."

### WILL-GRUNDY COUNTY

The following doctors have been invited to

speak before the Will-Grundy County Medical Society this fall: William J. Pickett, Willard Owen Thompson, Leo Amtman, J. Ernest Breed, Edward Lyman Cornell, all of Chicago.

## WINNEBAGO COUNTY

Dr. Anthony Daly, former Rockford physician who served 31 months in the army, more than half of which was spent in the European war zone, has resumed the general practice of medicine in Rockford.

## DEATHS

William Andrew Balcke, Pekin; St. Louis College of Physicians and Surgeons, 1898. Passed away quietly at home listening to the radio, August 14th, aged 71. Had practiced medicine in Pekin nearly 50 years.

Charles Oliver Bugler, Greenfield; University of Illinois College of Medicine, 1907. Died at his home, August 24th, aged 66.

Hubert B. Bradburn, Lincoln; Washington University School of Medicine, St. Louis, 1927. Served as major in the medical corps in Africa where he contracted malaria. Died of complications in Walter Reed hospital, Washington, D. C., Sept. 4th. He was 45 years of age.

Emil William Brust, Addison; Baltimore University School of Medicine, 1898. Had practiced medicine in Du Page County for 47 years. Died in his home, August 27, aged 70.

Harold Bernard Cassidy, Chicago; University of Illinois College of Medicine, 1927. Was formerly associated with the Indian Service; served during World War II. Died in July, aged 44.

Jennie Brookins Clark, Chicago; Northwestern University Woman's Medical School, 1887. Had practiced in Chicago over 50 years. Died August 20, aged 84.

Lucius Cole, Oak Park; Jenner Medical College, 1917. Had practiced medicine in Oak Park and River Forest for 30 years; was member of many Oak Park clubs and served on the selective service board during the war. Died August 30th in West Suburban Hospital where he had been a staff member for many years. He was 56 years of age.

James Terence Degan, Oak Park; Chicago College of Medicine and Surgery, 1916. Served during World War I. On staffs of the Alexian Brothers and St. Anne's Hospitals in Chicago and the West Suburban Hospital. Died June 10, aged 55, of cerebral hemorrhage.

Henry Foster Dice, Ridge Farm; Missouri Medical College, 1897. Former president of Vermilion County Medical Society. Had practiced medicine nearly 50 years. Died August 14th, aged 74.

Frank G. Douglass, Chicago; University of Illinois College of Physicians and Surgeons, 1910. Staff member of Englewood and St. George Hospitals. Died of a heart attack in his office, September 11th, aged 60.

Frederic Michael Groner, Yorkville; Loyola University School of Medicine, 1921. Was a member of the staff of St. Joseph Mercy Hospital in Aurora and former coroner for Kendall County. Died of a heart attack in his home, September 10th, aged 63.

Nathaniel George Hagler, East St. Louis; Chicago Medical School, 1933. Died in St. Mary's Infirmary, St. Louis, June 12, aged 54, of tuberculous meningitis.

Thomas Blackburn Knox, Quincy; College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, 1902. Served as councilor of the Illinois State Medical Society and in France during World War I; for many years on the staff of the Illinois Soldiers' and Sailors' Home and Hospital. Died in St. Mary Hospital May 27, aged 73, of coronary sclerosis.

Clifford O. McCreedy, Aledo, Illinois; Aged 41; Chicago Medical School, 1932; Killed August 7, 1946. Dr. McCreedy was touring the west with his family and at Laramie, Wyoming, his car was hit head on by another vehicle traveling out of control. Dr. McCreedy, his son John, age 10, and daughter Mary Jane, age 7, were killed instantly, and his wife remains in serious condition in Ivinson hospital, Laramie. The occupants of the other car were both killed.

Thomas Joseph Murphy, Chicago; Creighton University School of Medicine, Omaha, 1926. Died March 21, aged 43.

Josephine Milligan, retired, Jacksonville; Women's Medical College of the New York Infirmary for Women and Children, 1889. During World War I, she was one of a group of specialists sent to France by the Rockefeller foundation to combat tuberculosis. Died August 28th, aged 86.

John Leonard Nicolai, Chicago; University of Illinois College of Physicians and Surgeons, 1909. Body was found in Lincoln Park lagoon, August 22nd. Had given up the practice of medicine two years ago because of failing eyesight and ill health. He was 64 years old.

George Gwin Taylor, Springfield; St. Louis College of Physicians and Surgeons, 1897. In July, 1918, joined the department of public health as chief of the social hygiene division, serving through 1921. In 1942 rejoined the department, becoming chief of the division of venereal disease control. Died in the LaSalle Hotel fire in Chicago, June 5th, aged 70.

Richard J. Tivnen, Chicago; Rush Medical College, 1895. Clinical professor of ophthalmology at Loyola University School of Medicine. Had been awarded honorary doctor of law degrees from Loyola and Notre Dame universities. Author of several books and at one time president of the Ophthalmological Society and president of the Illinois State Eye, Ear, Nose and Throat Society. Died August 27th, aged 70.

Edward Otto Von Borries, Chicago; Kentucky University Medical Department, 1901. Had been plastic surgeon in Chicago for nearly 40 years. Died in his office, August 19th, aged 72.



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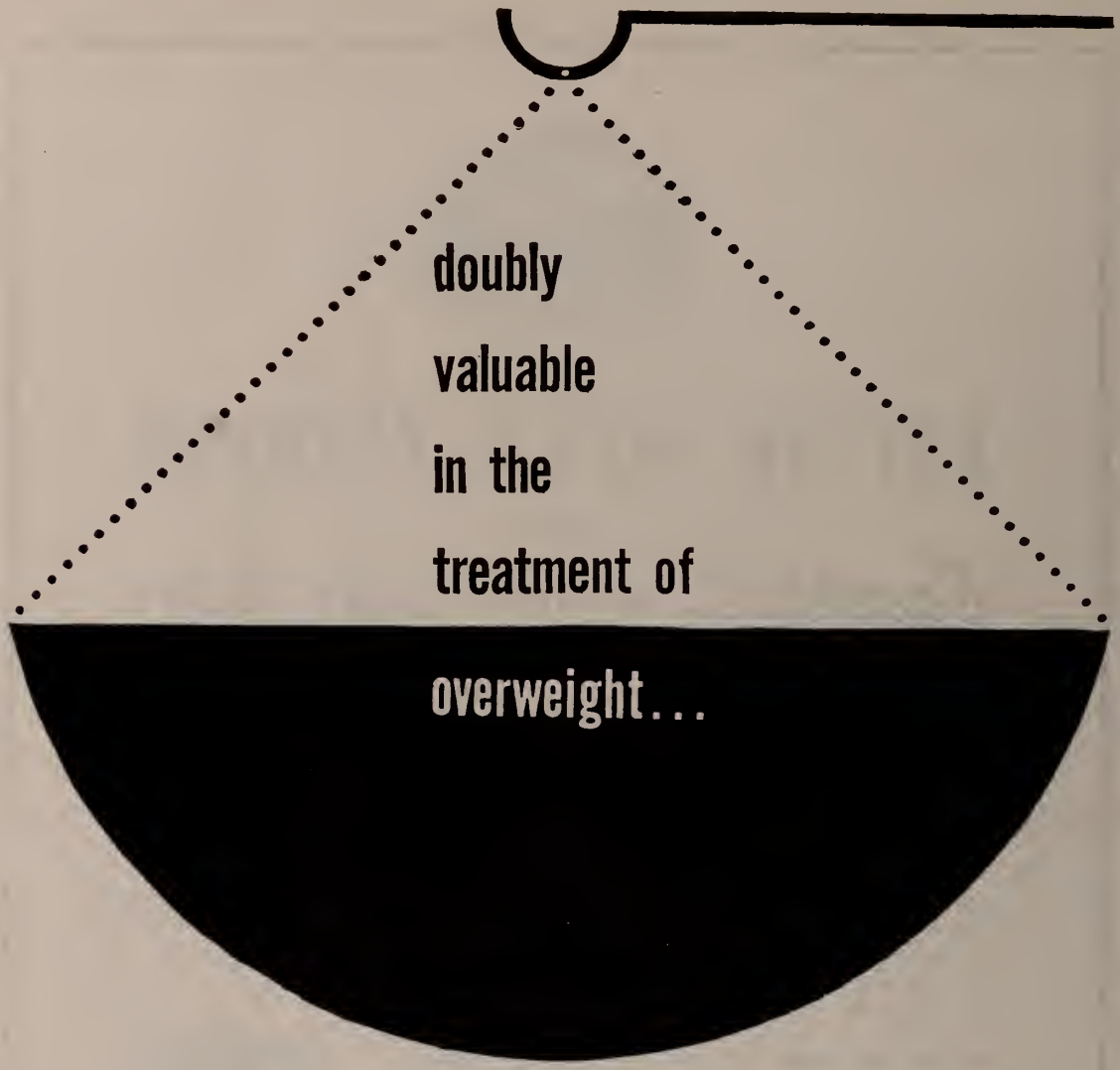
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*Canad. M. A. J. 54:26 (Jan.) 1946

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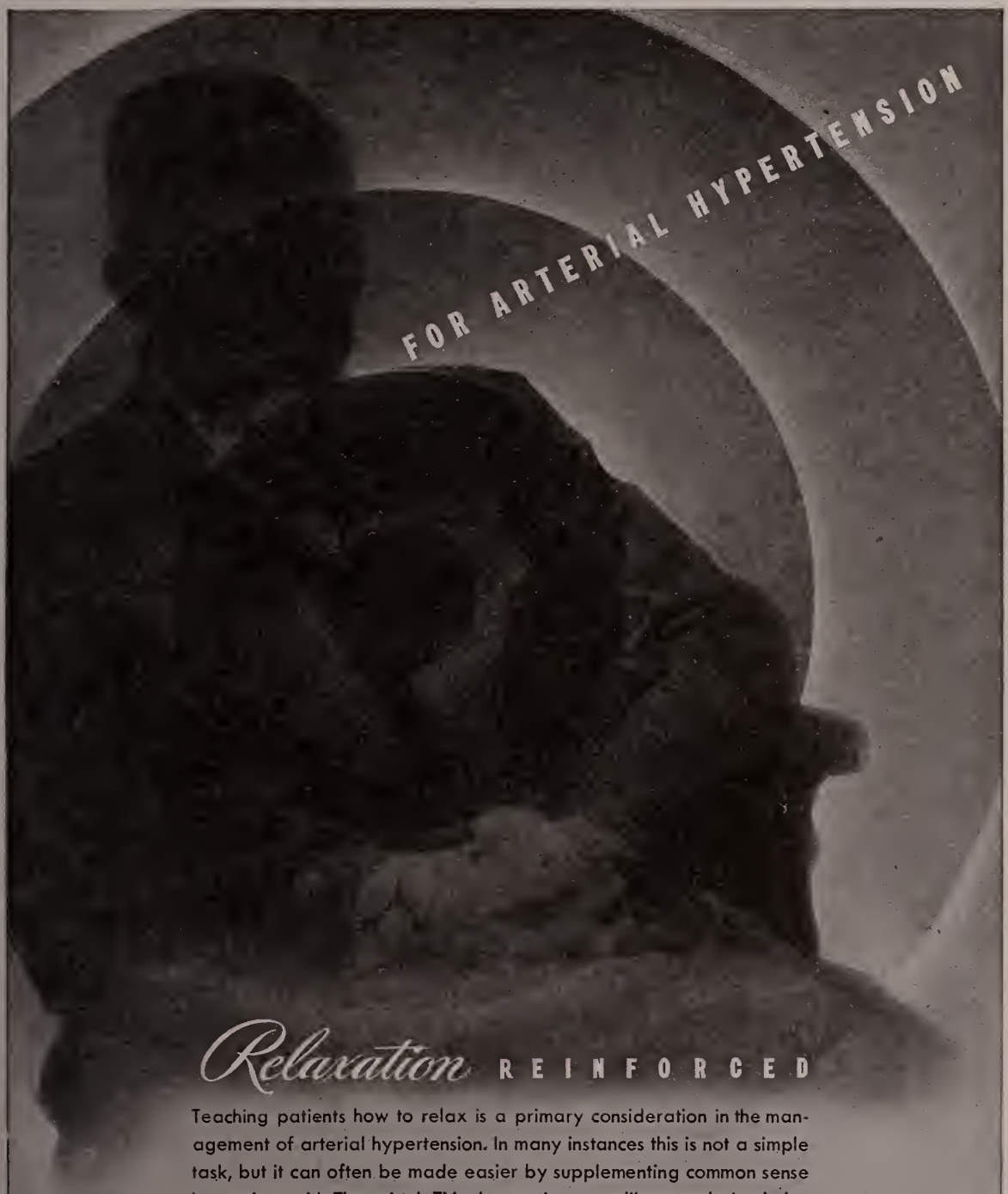
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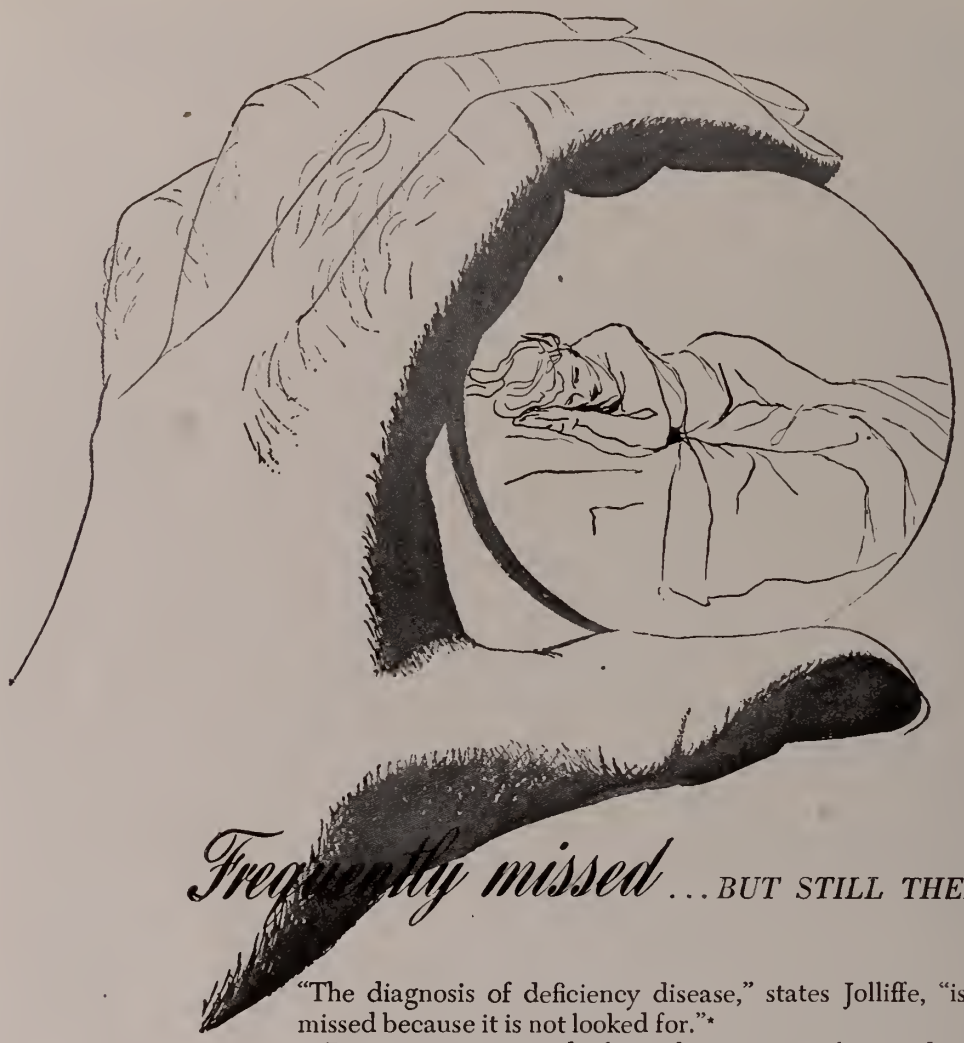
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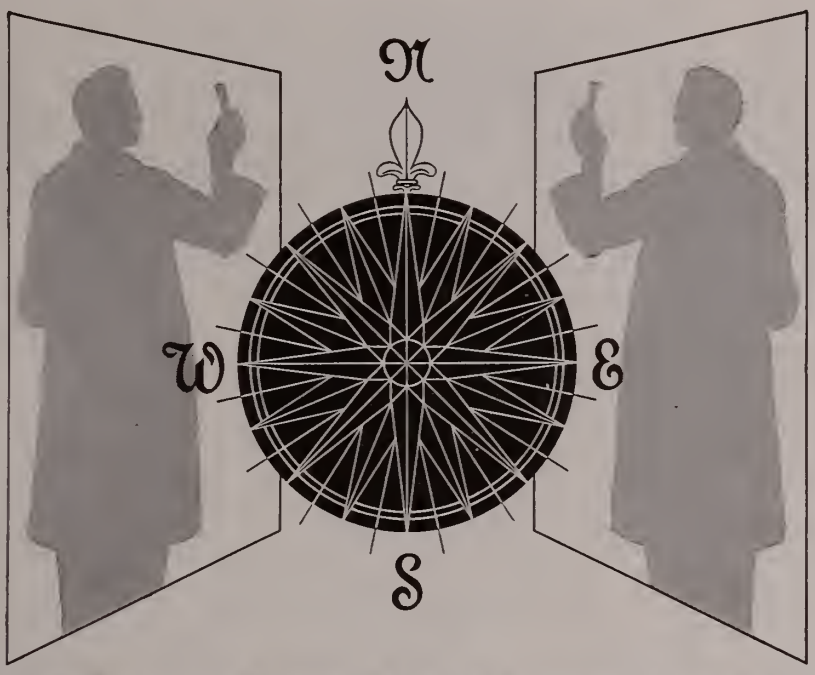
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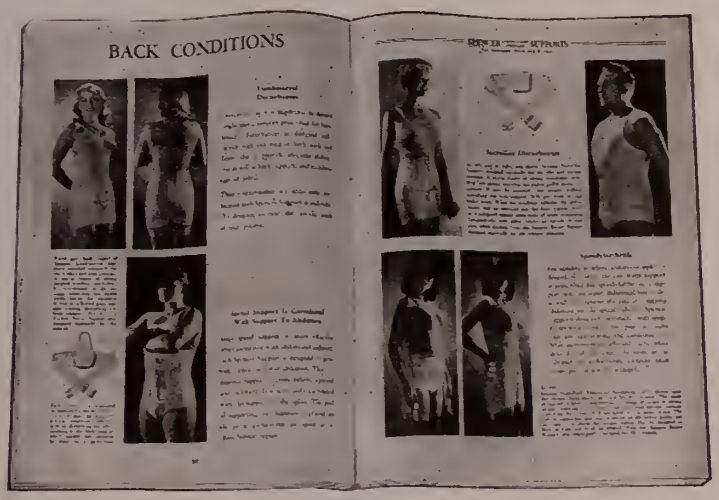
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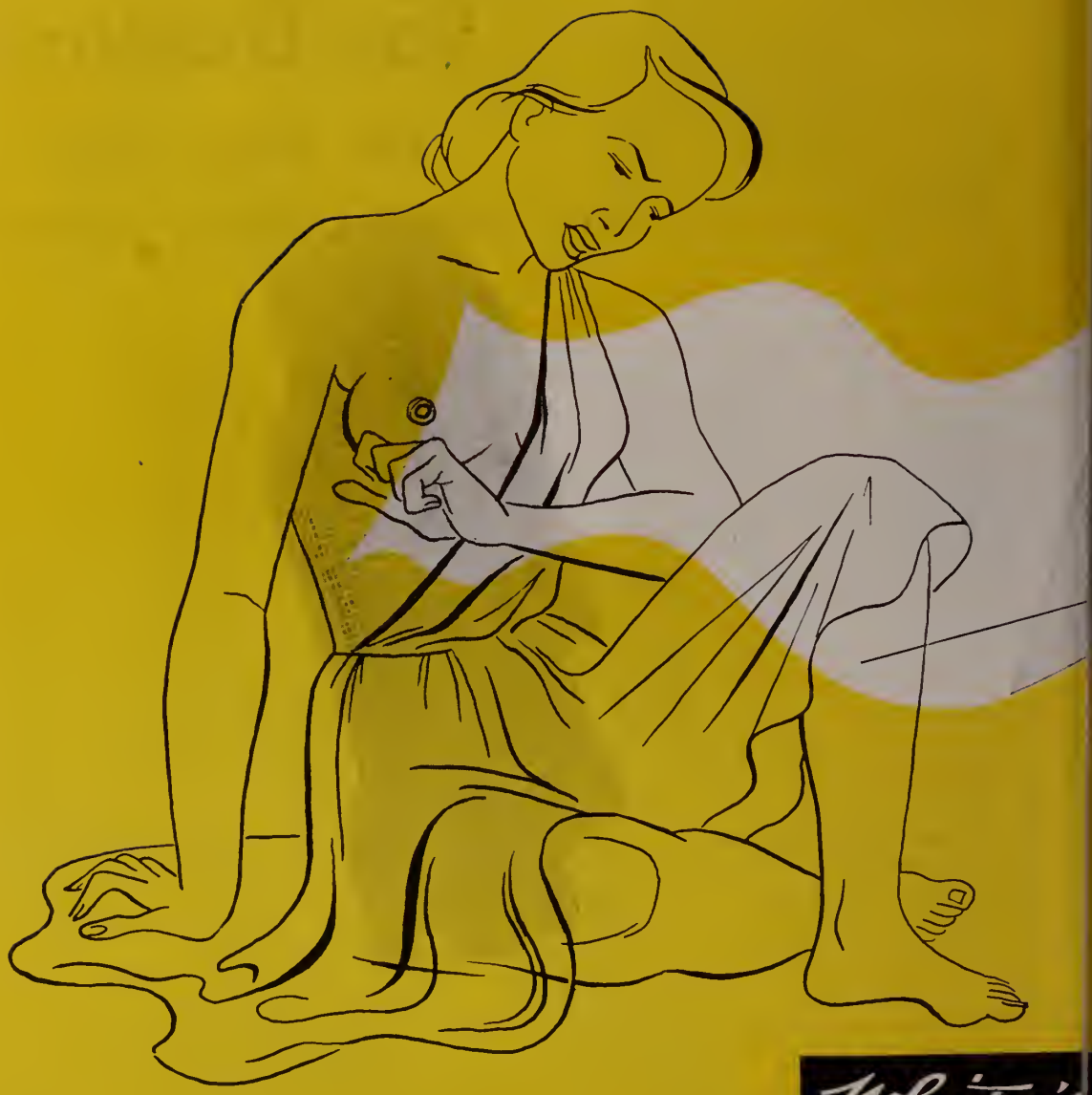
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# more rapid healing of

**FISSURED NIPPLES**

**BURNS**

**CHRONIC ULCERATIONS**

**ABSCESSES**

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Controlled investigation has shown a highly significant reduction in incidence of fissured nipples, infectious mastitis and breast abscesses when Vitamin A and D Ointment was topically applied to the puerperal nipple.* Suggested application is from the seventh month of pregnancy till the end of the puerperium.

Further, whenever skin or superficial tissues are damaged—(in severe burns, wounds that heal by secondary union, etc.)—White's Vitamin A and D Ointment promotes rapid epithelization, inhibits infection, minimizes skin grafting, prevents irritation, does not cause contractures, forms no tenacious coagulum.

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Available in ½ oz. tubes; 8 oz. and 16 oz. jars and 5 lb. containers.

*Brougher, J. D., Prevention and Treatment of Postpartum Fissured Nipples with Local Applications of Vitamin A and D Ointment, West. J. Surg., Obst. and Gyn. 52:520, 1944.

# Vitamin A and D ointment

# P. R. N.

The Jocular Jingles of C. G. F.

by

Charles G. Farnum M. D.
Peoria, Ill.

## RED LEAVES.

Our lives go through a cycle
Like leaves upon a tree,
That grow throughout their season,
Then reach senility.
Where most are withered, faded,
And many sombre brown,
And hordes of them are yellow,
But red leaves are the crown.
I care not where winds blow me,
Nor when nor what my fate —
I hope to be a red leaf,
A bright and cheery red leaf,
A gay and brilliant red leaf,
'Til I disintegrate.

## MOTHER EVE

Our mother Eve had simple taste
In clothing that she wore;
She did not time or temper waste
In any shop or store;
Without a thought of style or size
Her torso she'd entwine —
I trust that she could recognize
A poison ivy vine.
She brazenly could quite ignore
Dame fashions freak decrees,
She had a thousand garments more
On all the shrubs and trees,
She found new clothes at every turn,
Nor worried over cash —
I hope she never felt the burn
And sting of nettle rash.
The clothes she wore were trim and neat,
And new ones every day,
They never tangled up her feet,
Were never in the way,
Yet autumn brought a problem keen,
each year it would befall,
She had to change to evergreen
When leaves began to fall.

## LOONY LIMERICK

To see her brings joy and delight,
Her colors are all pink and whight,
She has platinum curls
And her teeth are like purls,
But how she can scratch and can bight.

## PATHOLOGICAL SONNETS

### Peptic Ulcer

Post prandial pain throughout a term of years,
Eructed gases tinctured acid sour,
I looked at food with many qualms and fears
My disposition surly, glum and dour.
Then came a vicious episode one day,
The old legs faltered and the head grew light,
My hands and face became a ghastly gray
The world grew dim and then as black as night.
I lay in bed for many, many days
With positive guaiacs and scanty food,
Resolved to change my dietary ways,
Adhere to what the regimen include.
Of course they put me on a rigid diet,
Some day, perhaps, I may decide to try it.

## FOLKS.

Why do we nonsense rhymsters write the things
we always write?
Why don't we write of gayer things more cheery and
more bright?
We wonder if it's simply from a disposition mean
Or something that our heritage has given us;
It might be plain perversion,
Perhaps a just aversion
To wild extremes the motley mob has driven us.
We're always writing diatribes,
And mostly vitriolic,
At fads and foibles, folks and things,
And always diabolic.
We write of fashions latest fad
Or custom interesting,
But always find ourselves, bedad,
Most viciously protesting —
At where man goes
And what he thinks,
His sporty clothes
Or what he drinks,
His hobby rare,
His noisy ties,
His lack of hair,
His alibis.
At women's shoes,
The way they walk,
Their freak hair-dos,
Their silly talk,
The awful gowns,
The crazy hat,
They look like clowns,
It's style at that.
Thus rhymsters get a kick from prodding people
as you see,
We jab them hard with all our sharpest pointed
jokes,
The reason for all this is very plain to you and me—
There's nothing quite so funny in this world as
Folks.

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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154.*
*Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60.*

TO THE DOCTOR WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

# Physical Medicine Abstracts

John S. Coulter, M.D.

## SOME MINOR MEDICAL MALADIES OF OLD AGE

Trevor H. Howell, M.R.C.P.Ed., Late Deputy Physician and Surgeon, Royal Hospital, Chelsea

In THE PRACTITIONER, 936;156;444
June 1946

### FIBROSITIS

For old people, the most beneficial line of *treatment* in this condition seems to be some form of heat combined with deep massage. Diathermy is not usually necessary, but infra-red rays, radiant heat, the radiations from a gas fire or an electric radiator, even a half-filled rubber hot-water bottle, may be used with benefit. It is important to have the affected site well and deeply massaged in order to break up the rheumatic nodules or corrugations. To forward this purpose, it was usual at the rheumatic clinic in the Royal Hospital to have compound ointment of mercury (Scott's dressing) massaged into the part while it was being heated under the lamp. This method gave good results, only 5 per cent of the patients not responding quickly.

### BACKACHE

The most common form of backache in old people is sacroiliac strain, which often ensues after unusual exertion. It responds well to support with Elastoplast, applied from the front of the anterior superior iliac spine, round the back, to a similar spot on the other side of the body. Two shorter, overlapping, parallel pieces below the first may be added with benefit: but all three must be drawn tight when applied, to give the best result. If this fails, short wave diathermy usually gives relief.

### DISORDERS OF THE NERVOUS SYSTEM

Another condition which is resistant to therapy is true *neuritis,* i.e., not secondary to fibrositis. The most suitable treatment in this disorder is rest, support and heat, to which some authorities add the use of the galvanic current. Massage is definitely contraindicated, and the less the patient uses the affected part, the better.

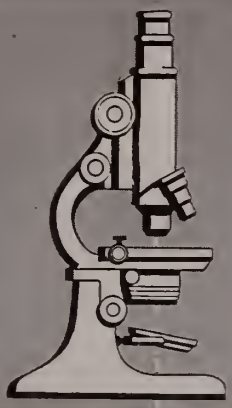
## PROGRESS IN THE TREATMENT OF SYPHILIS

Editorial

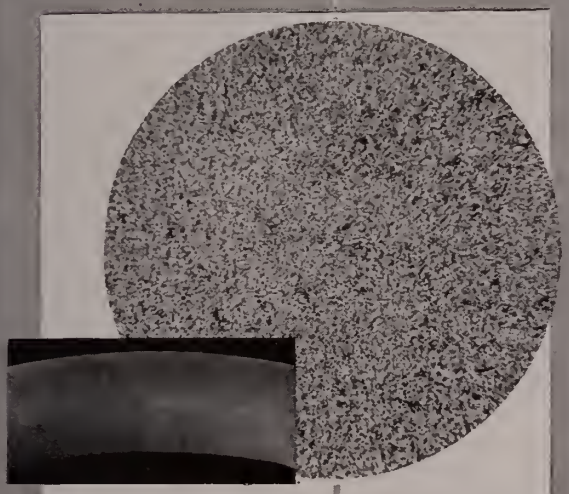
In BRITISH MEDICAL JOURNAL, No. 4454;766
May 18, 1946

It is a serious criticism of the treatment of syphilis by weekly injections of neoarsphenamine that a large proportion of the patients do not complete the course, remain infected, and are a source of danger to the community. In America, where syphilis appears to be a greater problem than it is here, steps have been taken to try other methods; and, indeed, a spirit of enterprise has been displayed which has resulted in commendable progress. It is true that American enthusiasm leads to the trial of measures some of which take our breath away, but their greater grasp of the principles of drug action and the experience they gain from their trials result in notable advances.

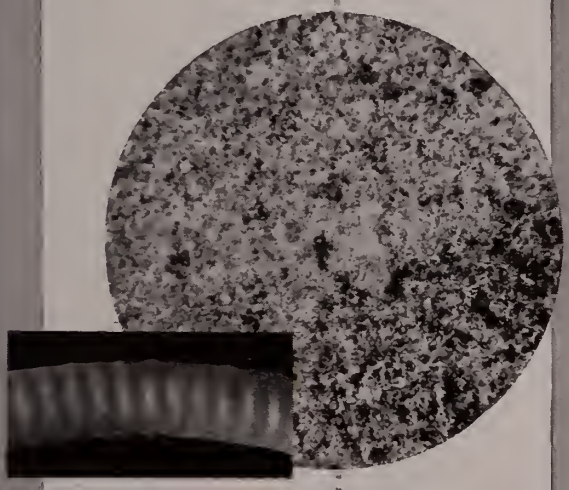
Not only in the treatment of early syphilis has knowledge been furthered: the relative value of malaria therapy and of artificial fever for neurosyphilis has been explored. In 1940 a committee reported on 1,100 paretic patients treated with malaria and on 320 treated with artificial fever. The results showed that about half the mild cases had remissions, whether they were treated with malaria or with artificial fever. Of severe cases, however, only 1% had remissions after malarial therapy, while 11% had remissions after artificial fever. Attempts have also been made to



# Through the MICROSCOPE



No. 1 Unretouched photomicrograph of the dome (enlarged 10 diameters) and the rim (inset) of a "RAMSES" Flexible Cushioned Diaphragm.



No. 2 Unretouched photomicrograph of the dome (enlarged 10 diameters) and the rim (inset) of a conventional-type diaphragm.

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## PHYSICAL MEDICINE (Continued)

apply a combination of mapharside and artificial fever to patients with neurosyphilis (Simpson, Kendell, and Rose) and also to patients with early syphilis, the crowning effort being a treatment intended to effect a cure in one day. This consisted in an initial dose of bismuth salicylate (0.25 g.) and then a 10-hour period of artificial fever at 106°F. (41°C.) (rectal temperature). During the first 7 hours of the fever 0.24 g. mapharside was given by intravenous drip. None of these attempts has been rewarded by much success.

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## THE USE OF DIATHERMY IN GENERAL PRACTICE

C. G. Garrenton, M.D., Bethel, North Carolina

In SOUTHERN MEDICINE & SURGERY,
108;5;147
May 1946

### INDICATIONS FOR THE USE OF SHORT-WAVE DIATHERMY

*Sprains* — At first it is advisable to use cold applications to help stop any deep bleeding that may occur.

*Bursitis* — Diathermy is almost a specific for subdeltoid bursitis.

*Tenosynovitis* — If the splint is removed daily and 20 minutes of diathermy applied, surprisingly good results will usually be achieved in this troublesome condition.

*Chronic Arthritis* — One should remember that often in a hypertrophic arthritis too much heat may aggravate the symptoms.

*Fibrositis* — Diathermy is an excellent method of relieving the pain and congestion associated with inflammation of the white fibrous connective tissue anywhere in the body.

*Pelvic Inflammations* — I still use diathermy in these conditions much to the apparent gratification of the patients. It seemed to give much relief before the advent of the sulfa drugs and penicillin, and I believe its use in conjunction with these drugs is quite justified. I have given 943 diathermy treatments for pelvic inflammation alone.

*Respiratory Diseases* — Diathermy treatment is excellent for the relief of the pain of pleurisy, allowing deeper breathing.

*Inflammations of the Peripheral Nerves* — In neuritis, radiculitis and neuralgia medical



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PHYSICAL MEDICINE (Continued)

diathermy is a welcome adjunct to general treatment.

*Sinusitis* — The best application is to the frontal and maxillary sinuses, but if there is not adequate drainage the pain may be increased by the congestion.

*Backache* — The causes of backache are legion, but most of them yield nicely to diathermy treatment.

---

## BLUEPRINT FOR AN IMPORTANT SERVICE PHYSICAL AND OCCUPATIONAL THERAPY

William Benham Snow, M.D., Director of Physical and Occupational Therapy, Columbia Presbyterian Medical Center, and N.Y. Orthopaedic Dispensary and Hospital, New York City

In THE MODERN HOSPITAL, 66;6;65
June 1946

The department of physical and occupational therapy should have as its director a physician who has certain personal attributes and professional qualifications.

The attending physician in physical medicine should have an understanding resident to carry on in his absence and to cover adequately the follow-up of his cases. A gap at this point often results in the therapist in charge advising attending physicians on treatment prescriptions or actually prescribing for patients himself.

Head therapists should be senior members of the department who are thoroughly acquainted with the routines of the institution and who understand the director of the department. Preferably, they should have risen from the ranks.

---

## PLANTAR WARTS (LOOP TREATMENT)

Florentine L. Karp, M.D., New York

In ARCHIVES OF DERMATOLOGY AND SYPHILOLOGY, 53;5;496
May 1946

A preliminary report on a method of treatment for plantar warts by electrosurgical removal was published in 1942. It covered observations for only 21 patients. Since that time I have treated 106 additional patients with the same method: therefore, the conclusion drawn in the preliminary report can be considered now as well established.

The high frequency cutting current is used as

AMINO ACIDS AND VITAMINS FOR...

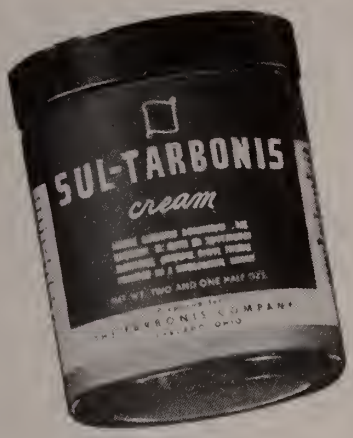
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## THE TARBONIS COMPANY

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offers these advantages to physician, laboratory technician, patient:

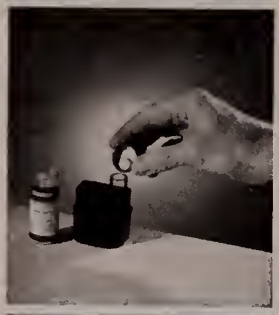
**ELIMINATES**

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Bulky apparatus
Measuring of reagents

**PROVIDES**

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Simply drop one Clinitest Tablet into test tube containing proper amount of diluted urine. Allow time for reaction, compare with color scale.

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PHYSICAL MEDICINE (Continued)

a means to destroy the plantar wart, and the source of the current should be a long wave diathermy machine capable of producing a cutting current of the necessary quality and quantity. Short wave diathermy machines are not generally satisfactory for the purpose.

In concluding this report, I wish to say that out of the total of 127 patients (some with multiple lesions) treated with the loop method only 7 have not responded favorably to the treatment. In this series of 127 patients many had received previous treatments, including roentgen irradiation, without benefit.

The percentage of cures in the 127 patients is 95.51 per cent. All warts were of the common plantar type. No mosaic plantar warts were treated.

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# Book Reviews

A MANUAL OF SURGICAL ANATOMY: Prepared under the Auspices of the Committee on Surgery of the Division of Medical Sciences of the National Research Council, by Tom Jones and W. C. Shepard. 195 pages with 267 illustrations on 138 figures, 153 in colors. Philadelphia and London: W. B. Saunders Company. Price $5.00.

This volume is another in the already popular series of Military Surgical Manuals developed under the auspices of the Division of Medical Sciences of the National Research Council to furnish the medical department of the Army and Navy with compact presentations of necessary information in the field of surgery.

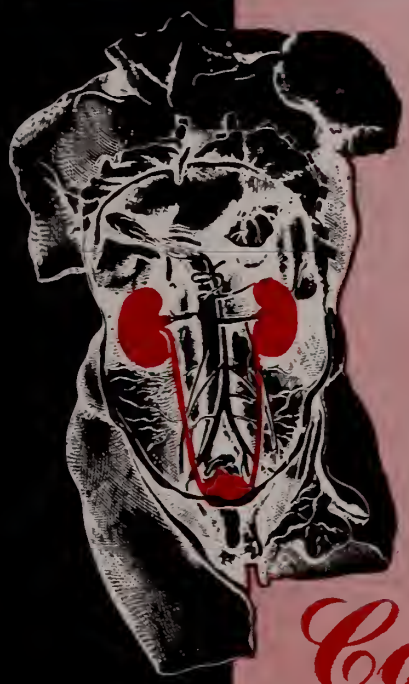
Forewords written by the Surgeons General of the U. S. Army and U. S. Navy highly approve this volume, and contain the prediction that this work will continue to be popular now that the war is ended, even more so than other manuals which have been prepared previously for the use of the Army-Navy Medical Corps.

An effort has been made to make it easier for the surgeon to refresh his memory of the anatomical features likely to be involved in an operation on any part of the body.

The material is divided into sections: head and neck;

# *Reducing Renal Hazards*

# During Sulfonamide Therapy



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Bottles of 100 and 1,000 tablets.

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**BIBLIOGRAPHY:** (1) Lehr, D.: Proc. Soc. Exper. Biol. & Med. 58:11, 1945. (2) Lehr, D.: J. Urol. 55:548, 1946.

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## BOOK REVIEWS (Continued)

trunk-thorax, abdomen and pelvis; upper extremity; lower extremity, etc., and in each instance beginning with the bones, ligaments, muscles, veins and nerves, shows many dissections and continues with the surgical approaches.

Having been prepared under the supervision of a group of master surgeons, and by two of the outstanding anatomical artists, the popularity of this book should continue for a long time.

---

THE MANAGEMENT OF FRACTURES, DISLOCATIONS, AND SPRAINS: By John Albert Key, B.S., M.D., St. Louis, Mo., Clinical Professor of Orthopedic Surgery, Washington University School of Medicine; Associate Surgeon, Barnes, Children's and Jewish Hospitals; and H. Earle Conwell, M.D., F.A.C.S., Birmingham, Ala., Orthopaedic Surgeon to the Tennessee Coal, Iron and Railroad Company; Chairman of the Committee on Fractures and Traumatic Surgery of the American Academy of Orthopaedic Surgeons. Member of the Fracture Committee of the American College of Surgeons, etc. Fourth Edition. St. Louis, The C. V. Mosby Company, 1946. Price $12.50.

The fact that this book has gone into its fourth edition in 12 years speaks well for its popularity. As would be expected, following the vast experience gained through the management of many thousands of fracture cases during the war, and the many changes in care given to these casualties, a new edition would, and should be forthcoming.

Originally intended for the use of students and general practitioners as well as surgeons, the authors have always endeavored to present information concerning the care of fractures, sprains and dislocations so that the book would be of value to each of these groups. There are many changes in the text since the last edition was published, especially in reference to lesions of the hip, spine, and concerning compound fractures.

The book is divided into two parts: the first dealing with principles and general aspects, with a chapter on Workmen's Compensation Laws affecting fracture cases and the medico legal aspects, both of which are of much importance to the physician caring for this type of injury.

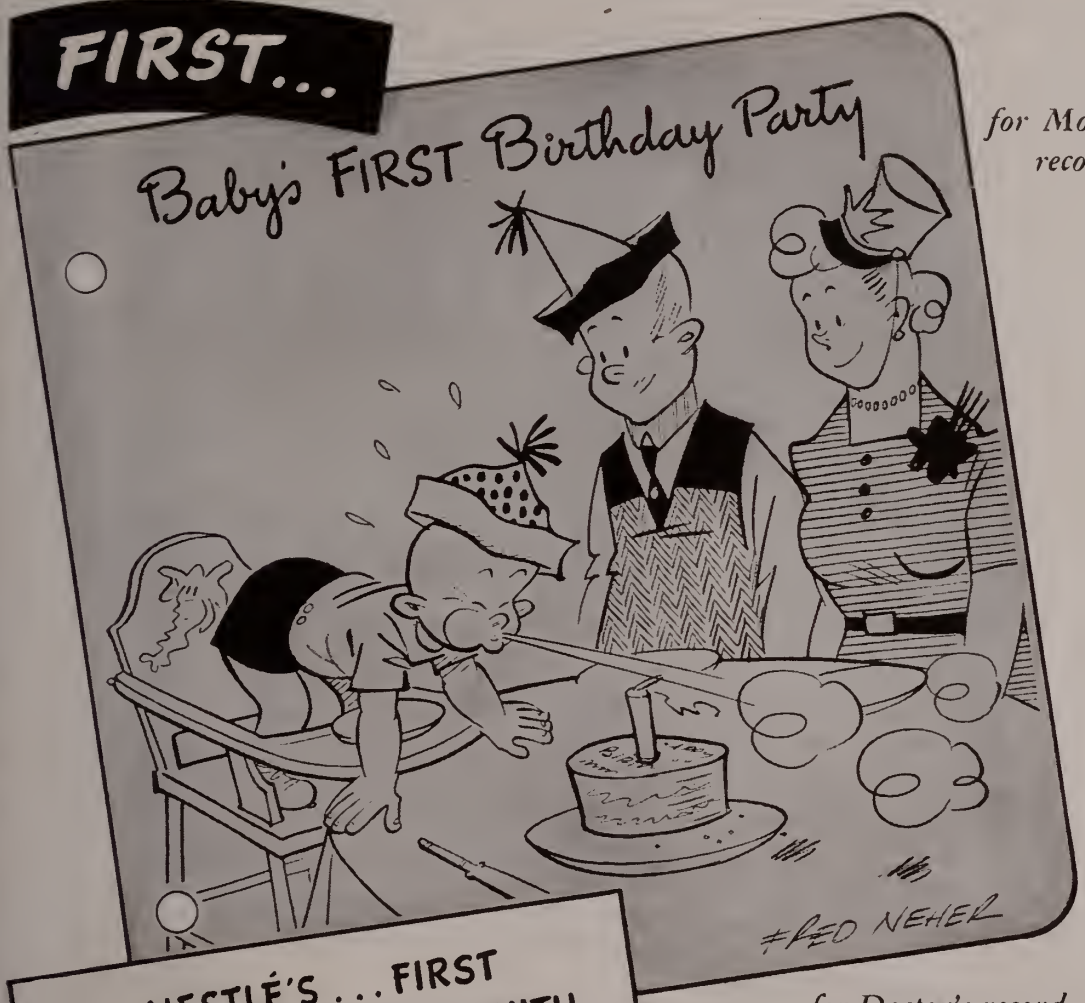
With the ever increasing number of automobile accidents, one chapter is devoted to this subject.

The second division of the book deals with diagnosis and treatment of specific injuries, and has been completely revised and rewritten in keeping with the medical progress of the past four years and the vast change in management of many types of injuries brought out following war injuries.

Penicillin, along with the sulfa drugs, is also used in the treatment of old infected compound fractures, especially following surgery in this type of case. As would be expected, there is a chapter devoted to compound fractures and war wounds which describes the



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WISCONSIN ALUMNI RESEARCH FOUNDATION APPROVED FOR VITAMIN D UPON PERIODIC TESTS

**SAFE, SURE, ADEQUATE SOURCE OF VITAMIN D**

BOOK REVIEWS (Continued)

methods in general use and those which have been used successfully by the authors.

The chapter devoted to injuries in the region of the hip contains more than 100 pages and will be of interest to all readers. Along with the simpler methods of treatment, the authors have endeavored to express their preferences as to the indications for and the type of appliances to use in operative treatment of fractures of the neck of the femur. The most popular methods are described, with their indications, technique, and after-care.

Injuries of the spine likewise receive much consideration. Under the section on low back pain, lesions of the intervertebral discs are discussed and the use of spinograms in making the diagnosis is well outlined and shown in the excellent accompanying illustrations. One of the authors believes that in practically all of the patients with idiopathic low back pain or low back strain, the lesion is in the disc. He also believes that many of these discs are concealed, protruding but not ruptured, and may not be shown by spinal myelography. Operation in this type of case is considered only when the conservative methods of treatment do not bring relief.

There is much that is new in this fourth edition, and as has been the case in recent years, the book should be of much value to any physician treating fractures, dislocations and sprains, and it should be a MUST in the library of physicians everywhere.

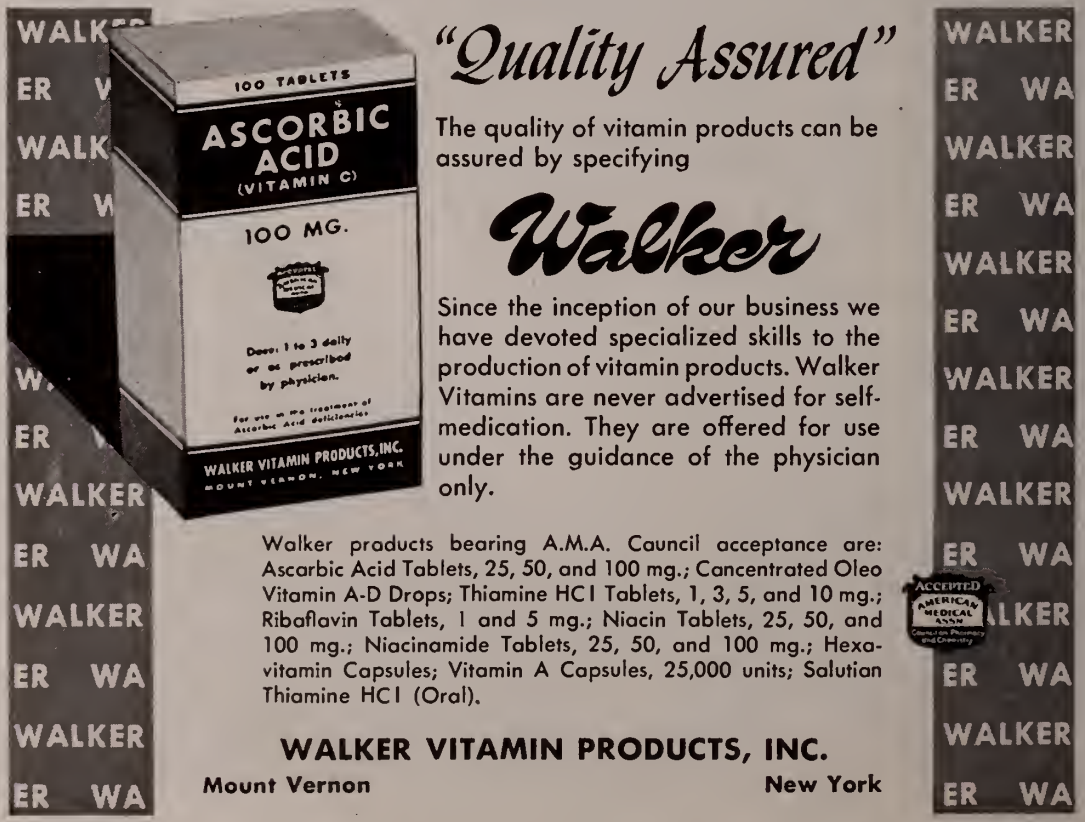
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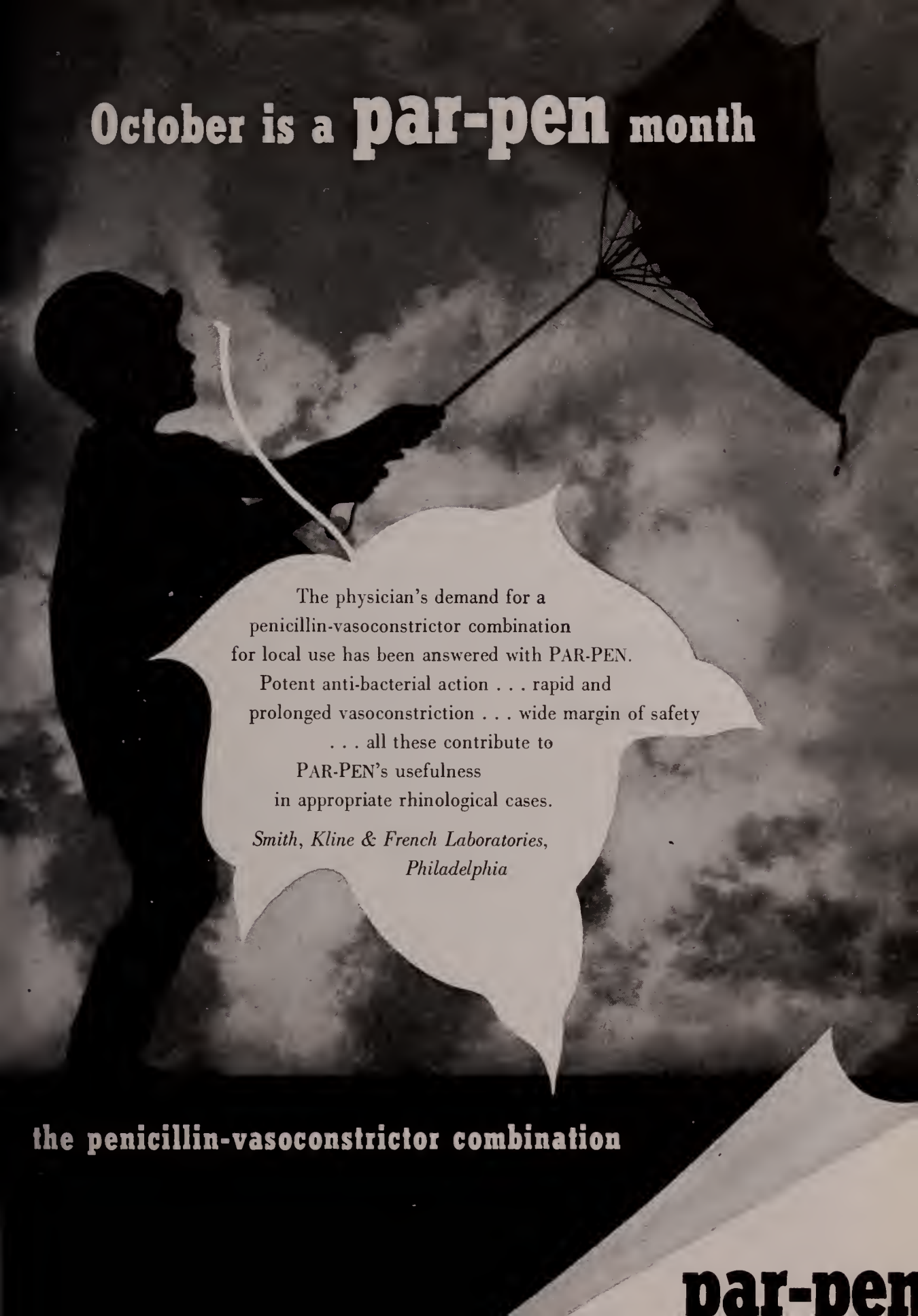
**The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.**

A PRIMER FOR DIABETIC PATIENTS: An Outline of Treatment for Diabetes with Diet, Insulin and Protamine-Zinc Insulin, Including Directions and Charts for the Use of Physicians in Planning Diet Prescriptions; by Russell M. Wilder, M.D., Ph.D., F.A.C.P. Professor and Chief of the Department of Medicine of Mayo Foundation, University of Minnesota; Senior Consultant in Division of Medicine, Mayo Clinic. Eighth Edition, Reset. 192 pages, wth 8 illustrations. Philadelphia and London: W. B. Saunders Company, 1946. Price $1.75.

UROLOGIC ROENTGENOLOGY: By Miley B. Wesson, M.D., Ex-President, American Urological Association. Second Edition, Thoroughly Revised. Illustrated with 258 Engravings. Lea & Febiger, Philadelphia, 1946. Price $5.50.

TRANSVISION ANATOMY OF HEAD STRUCTURES INVOLVED IN THE PROBLEMS OF ORAL PROSTHESIS: Wernet Dental Manufacturing Company of Jersey City, N. J. 1946. Price $1.00.




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## PENICILLIN BRINGS SPEEDY RECOVERY IN SKULL INFECTIONS

Penicillin offers the patient suffering from infections involving the central nervous system and skull the most effective and rapid way to recovery, according to five San Francisco investigators.

Writing in the August 10 issue of *The Journal of the American Medical Association,* H. C. Naffziger, M.D., Helen Warmer, A. B., Walter E. Stern, M.D., Roberta Fenlon, M.D., and H. J. McCorkle, M.D., from the Division of Surgery of the University of California Medical School, say that during the past two years they gave penicillin to 37 patients with infections involving the central nervous system and skull.

Treatment consisted of penicillin injections into the muscles at three hour intervals, lasting anywhere from six to 114 days. The total dosage of penicillin varied from 745,000 units for those patients with infections of the skull bones but no central nervous system involvement to 36,500,000 units for patients who had signs indicating localized areas of infection within the skull.

The authors say that the response to penicillin treatment was very good in nearly all cases, often referring to the results as "excellent."

The article points out that "in three patients with pneumococcic meningitis definite localizing signs were observed indicating intracranial abscesses origininating from acute mastoiditis. Although the surgeons declined to operate on these three patients because of their critical, apparently hopeless condition, all three recovered after prolonged penicillin therapy."

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MEDICAL EXAMINERS (Continued)

disability, that is physicial findings and objective symptoms, is required, *"AND THE FINDINGS AND SYMPTOMS MUST ADEQUATELY SUPPORT THE DIAGNOSIS"*; also *"WITH RESPECT TO CLAIMED DISABILITIES THE NEGATIVE FINDINGS MAY BE EQUALLY AS IMPORTANT AS THE POSITIVE FINDINGS"*.

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*Scars* — Origin, size, shape, location, whether adherent, motion and function of adjacent struc-



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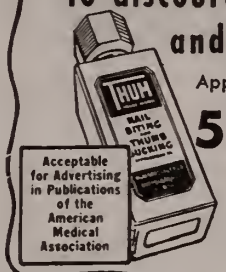
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*Fractures* — Deformity, swelling, shortening, gait degree of limitation of motion.

*Peritoneal Adhesions* — History of abdomonal surgery. Symptoms of disturbance of motility. Evidence of actual partial obstruction. Reflex disturbance or presence of pain.

*Peptic Ulcer* — Symptoms of vomiting, blood, pain (character and frequency of each). Necessity for restricted diet and medication. Foods which disagree, time of or proximity to meals of attacks of pain.

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3/47

## MEDICAL EXAMINERS (Continued)

of attacks.

*Epilepsy* — Grand mal, petit mal, frequency, duration, and severity. Time of day of attacks.

*Malaria* — Frequency, duration, and frequency of attacks, number since discharge. Kind and amount of medication necessary to control, splenic enlargement. Evidence of general impairment of health.

*Trench Feet* — Symptomatic or not, and if symptomatic, signs of swelling, redness, tenderness, skin changes, attributable to re-exposure.

It is important to refer to the "Manual for Medical Examiners of the Veterans Administration" (Edition of 1940) for the specific coverage of the disability in question.

B. A. Cockrell
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Infection with tuberculosis may be compared to the action of an incendiary bomb. It may come to rest in any isolated area of the body, generally first in the upper respiratory passages, and then may quickly be dispersed to other areas, like the bomb fragments causing incendiary fires.

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*Frazer, J. G.: The Golden Bough, vol. 1, New York, Macmillan & Co., 1923.



It is ironical that the practice of attempting to cure rickets by holding the child in the cleft of an ash tree was associated with the rising of the sun, the light of which we now know is in itself one of Nature's specifics.

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November, 1946

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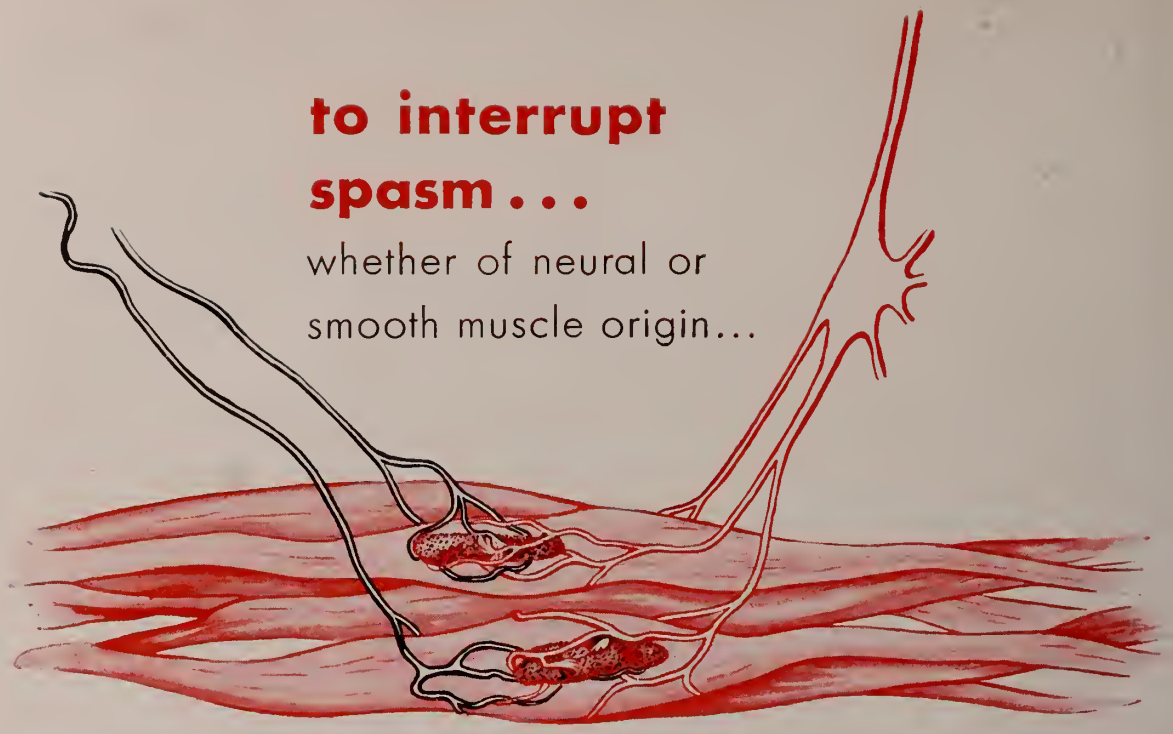
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(See Page 39 for complete Table of Contents)

OFFICIAL JOURNAL OF THE ILLINOIS STATE MEDICAL SOCIETY



**to interrupt spasm . . .**

whether of neural or smooth muscle origin...

## **PAVATRINE** with PHENOBARBITAL

(β-diethylaminoethyl fluorene-9-carboxylate hydrochloride)

—combines the musculotropic and neurotropic effects of the new, synthetic antispasmodic, Pavatrine, with the gentle sedative action of Phenobarbital.

Especially useful in the management of gastrointestinal spastic states, dysmenorrhea, urinary tract spasticity and related conditions.

Pavatrine is the registered trademark of G. D. Searle & Co., Chicago 80, Illinois.

**SEARLE**

RESEARCH IN THE SERVICE OF MEDICINE


Entered as Second-Class Matter July 21, 1919, at the Post Office, Oak Park, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate of postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Office of Publication, 715 Lake Street, Oak Park, Ill.

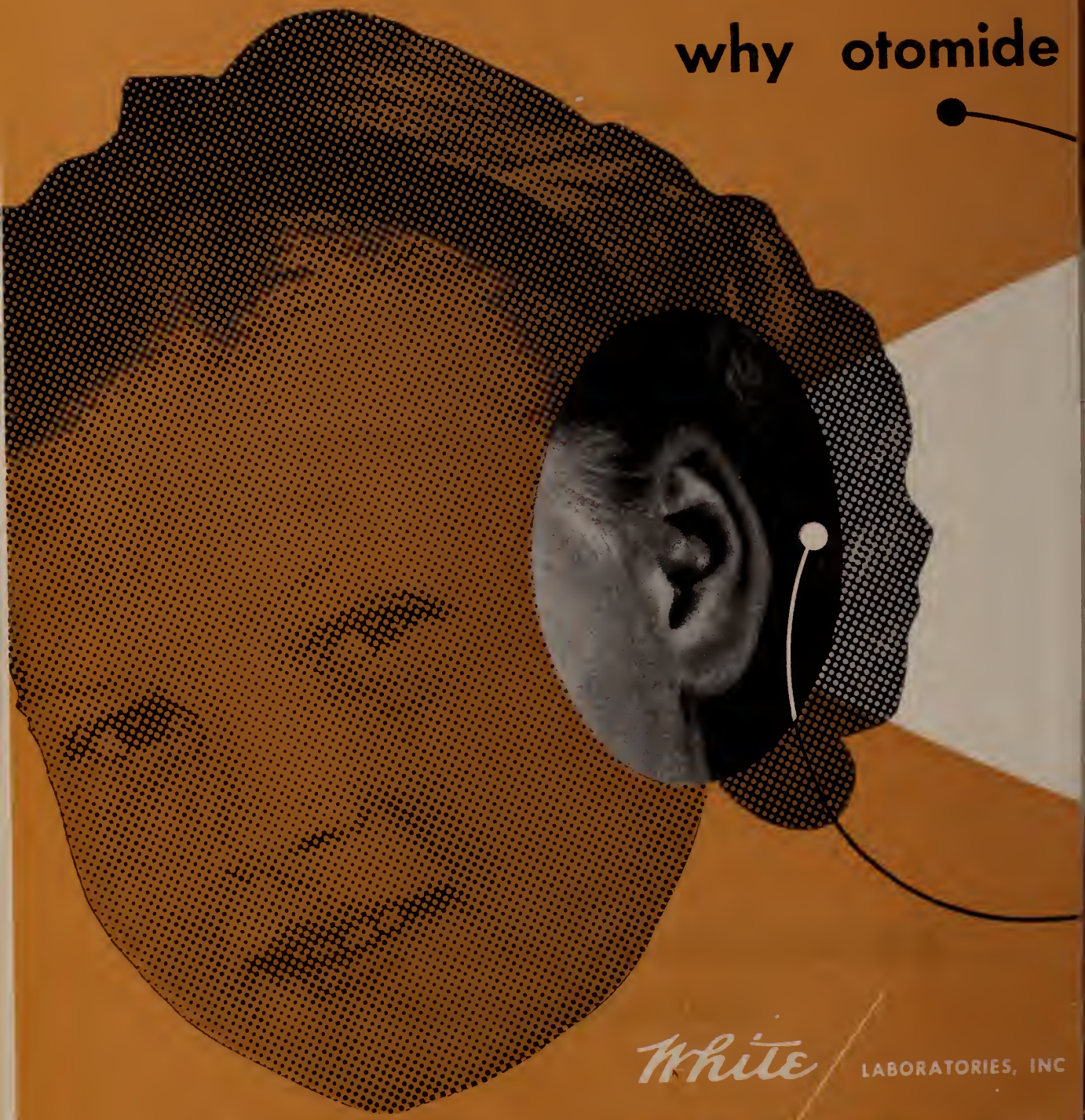
# Thanksgiving

Our fathers' God! from out whose hand
The centuries fall like grains of sand
We meet today, united, free,
And loyal to our land and Thee,
To thank Thee for the era done,
And trust Thee for the opening one.

Whittier

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

# why otomide



White LABORATORIES, INC

Pharmaceutical Manufacturers, Newark 7, N. J.

# in otologic chemotherapy?

**BECAUSE . . .**

1. Effective in BOTH acute AND chronic otitis media.
2. Has enhanced antibacterial potency.
3. Diffuses more completely into infected tissues.
4. Effects micro-debridement by chemical action on necrotic tissues.
5. Promotes effective local analgesia—without impaired sulfonamide activity.
6. Is free from unphysiologic alkalinity or distressing side actions.
7. Rapidly controls noxious odor of purulent discharge.

White's Otomide is composed of 5% Sulfanilamide, 10% Urea (Carbamide) and 3% Anhydrous Chlorobutanol in a specially processed glycerin vehicle of unusually high hygroscopic activity.

Supplied in dropper bottles of ½ fluid ounce (15 cc.)


**BIBLIOGRAPHY**

Strakosch, E. A. and Clark, W. G.: Minn. Med., 26:276-282 (Mar.) 1943.
Tsuchiya, H. M. et al.: Proc. Soc. Exp. Biol. and Med., 50:262-266 (June) 1942.
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Ashley, R. E.: Trans. Am. Acad. Ophth. and Otolaryng., 46:257-264 (July-Aug.) 1942.


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combination radiographic-fluoroscopic
diagnostic x-ray apparatus

penetrating

stable

intranasal antibiotic

Quicker acting, more penetrating and more stable than penicillin is tyrothricin, the nontoxic antibacterial principle of 'Prothricin' Antibiotic Nasal Decongestant. Applied locally, tyrothricin promptly attacks bacteria, and its low surface tension promotes penetration of tissue crevices and mucosal folds.

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Finally, 'Prothricin' Antibiotic Nasal Decongestant is stable, retaining full antibacterial potency indefinitely at room temperature. This unique preparation is indicated in the local treatment of sinusitis, rhinitis, coryza and nasal congestion.

*Supplied in 1-ounce, dropper-assembly bottles.*

Sharp & Dohme, Philadelphia 1, Pa.

*Council-Accepted

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'PROTHRICIN'

*antibiotic nasal decongestant*

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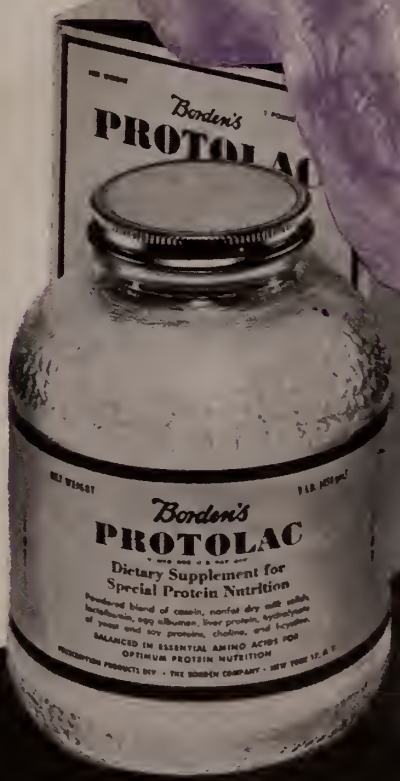
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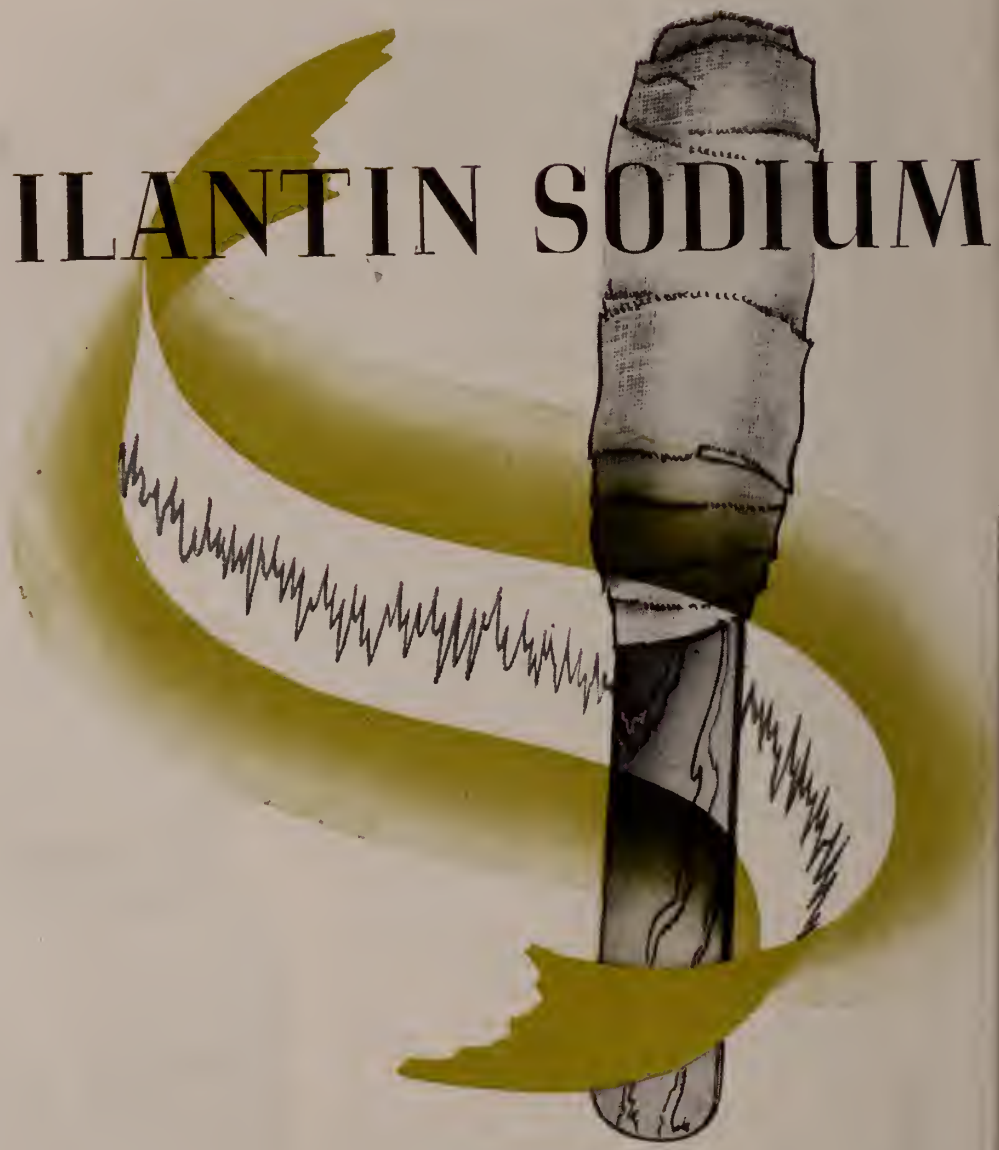
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*The cry, the fall,* the champing teeth, the tonic and clonic contractures, the incontinence—all may yield to DILANTIN SODIUM. The E.E.G. can trace the pathologic brain wave, yet the epileptic may be spared his terrifying episodes. Powerfully anti-convulsant rather than dullingly hypnotic, DILANTIN SODIUM KAPSEALS* offer to the epileptic a sense of security and an opportunity to lead a more normal and useful life. DILANTIN SODIUM KAPSEALS—another product of revolutionary importance in the treatment of a specific disease; another of a long line of Parke-Davis preparations whose service to the profession created a dependable symbol of significance in medical therapeutics—MEDICAMENTA VERA.

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Scarano, J. A., and Coppolino, J. F.: Arch. Pediat. 54:97

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Details of administration accompany each package of SOLGANAL-B OLEOSUM; or they may be obtained by writing the Medical Research Division.

1. Ragan, C., and Boots, R. H.: New York Med. 2:21, 1946.

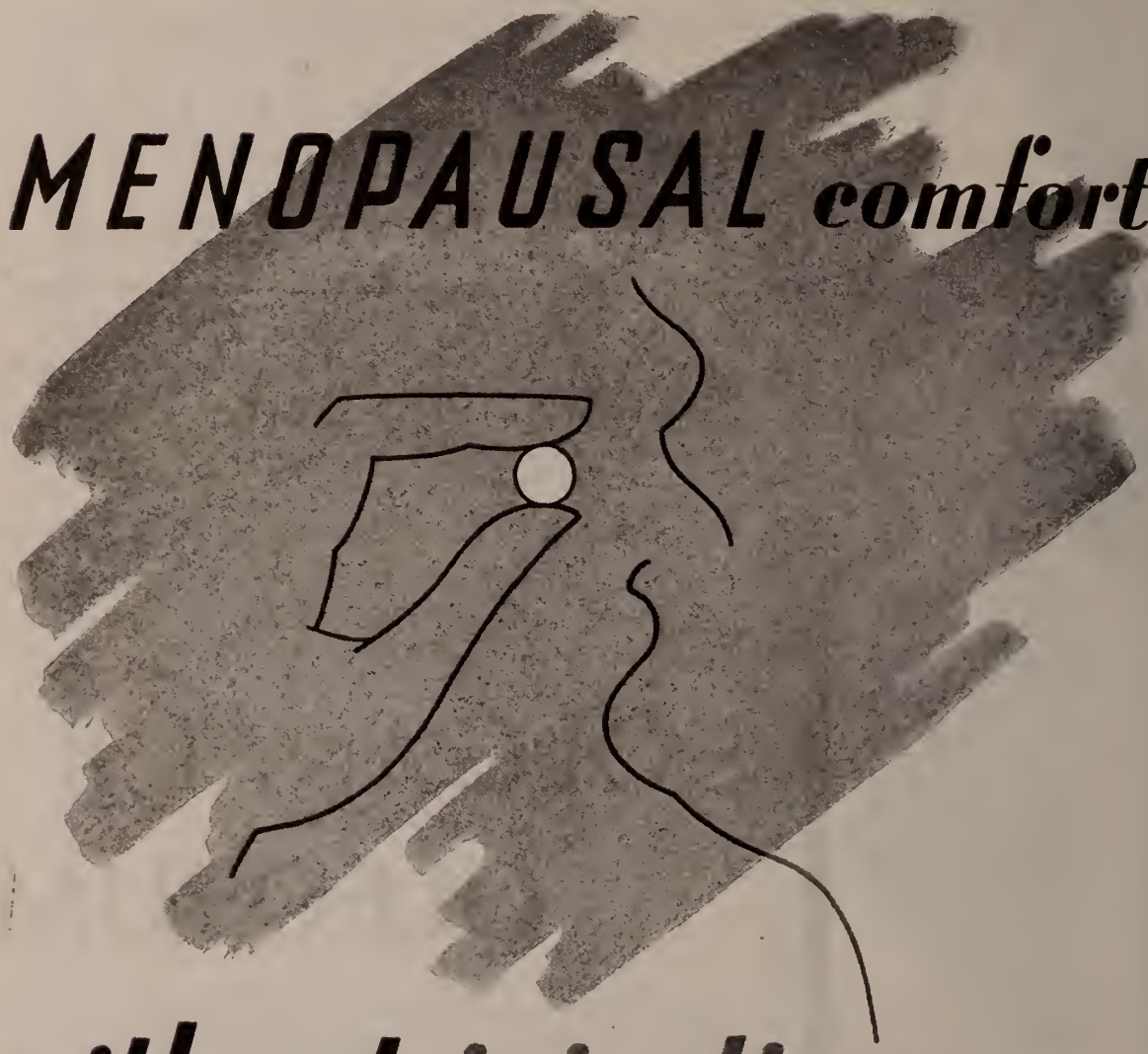
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(1) F. E. Harding, *Am. J. Obst. & Gynec.*, *48*:181, 1944




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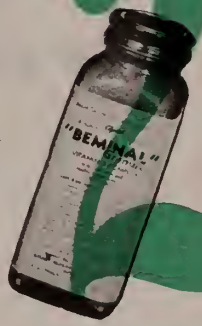


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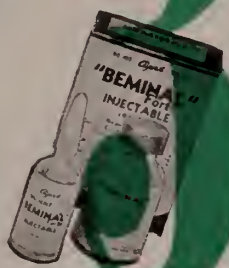


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**INJECTABLE**
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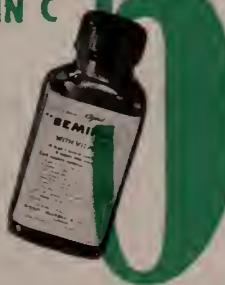


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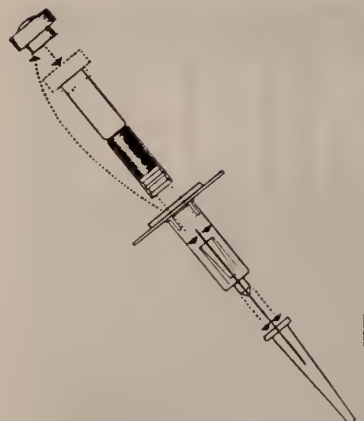


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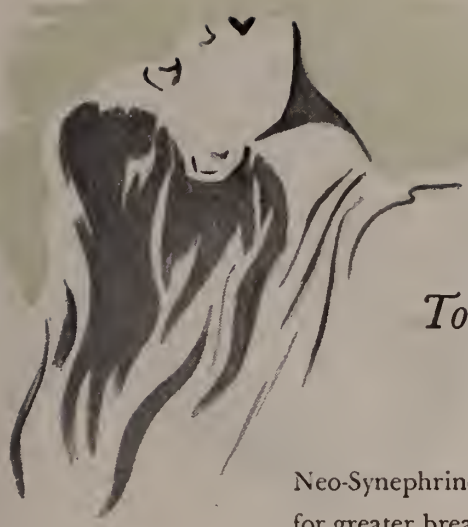


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(ROMANSKY FORMULA)
*with the B-D disposable cartridge syringe*



*To restore nasal patency in colds and sinusitis . . .*

Neo-Synephrine decongests promptly . . . clears the nasal airways for greater breathing comfort . . . promotes sinus drainage. Relief lasts for several hours. Virtual freedom from compensatory vasodilatation precludes development of dependency symptoms.

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BRAND OF PHENYLEPHRINE HYDROCHLORIDE

*For Nasal Decongestion*

**THERAPEUTIC APPRAISAL:** Prompt, prolonged nasal decongestion without appreciable compensatory recongestion; virtual freedom from local and systemic side effects; sustained effectiveness on repeated use.

**INDICATED** for symptomatic relief of the nasal congestion of common colds, sinusitis and allergic rhinitis.




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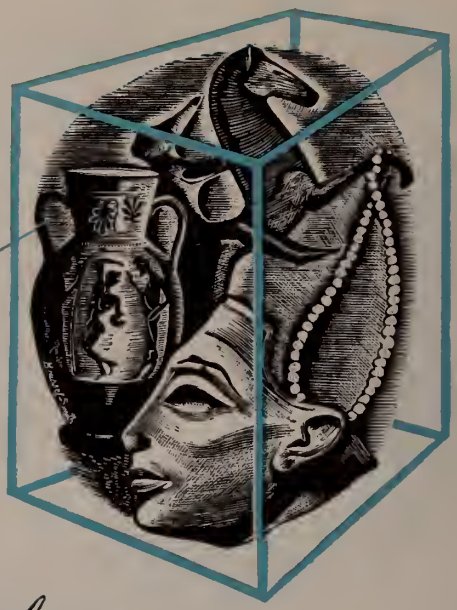
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*Bottles of 100's and 250*

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### Refined and Concentrated

(Bio. 350)

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

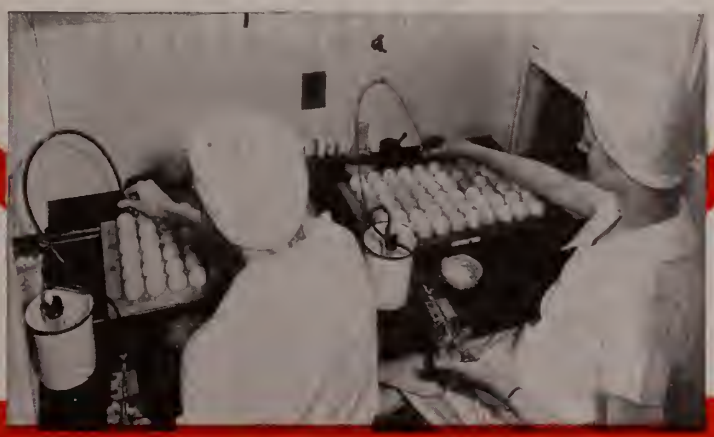
PREPARED from Influenza Virus, Types A and B, propagated in the extraembryonic fluids of the developing chick embryo, concentrated, refined by the red cell elution method, inactivated, and preserved with sodium ethyl mercuri thiosalicylate.

Influenza virus vaccine is one of the outstanding medical contributions of World War II. Likewise, its production in tremendous quantities was one of the war-time contributions of the Pitman-Moore Laboratories.

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*Supplied in 1 and 5-dose packages*



*Above: Harvesting the virus-laden extraembryonic fluids from partially incubated eggs, impregnated with influenza virus.*

*Left: Injecting influenza virus into eggs. During incubation the virus multiplies in the extraembryonic fluids.*

**PITMAN-MOORE COMPANY**

PHARMACEUTICAL AND BIOLOGICAL CHEMISTS

*Division of Allied Laboratories, Inc. · Indianapolis 6, Indiana*

# *It's prescribed*

*Rhinitis . . .*

*Sinusitis . . .*

*Nasopharyngitis . . .*

*Pharyngitis . . .*

# *Paredrine-Sulfathiazole Suspension*

*Vasoconstriction in minutes*

*. . . Bacteriostasis for hours*

# *because it* works . . .



(*Left*) **Before administration of Paredrine-Sulfathiazole Suspension:** Turbinates acutely inflamed, highly engorged, and in contact with septum. Air passage completely blocked.

(*Right*) **30 minutes after instillation of Paredrine-Sulfathiazole Suspension:** Turbinates constricted; ventilation and drainage promoted. Infected areas rendered accessible to the sulfathiazole, which is lightly frosting inferior and middle turbinates.

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*N. Y. State Journ. Med. 35 No. 11,590
Laryngoscope 1935, XLV, No. 2, 149-154

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| Vitamin D | 500 U. S. P. units |
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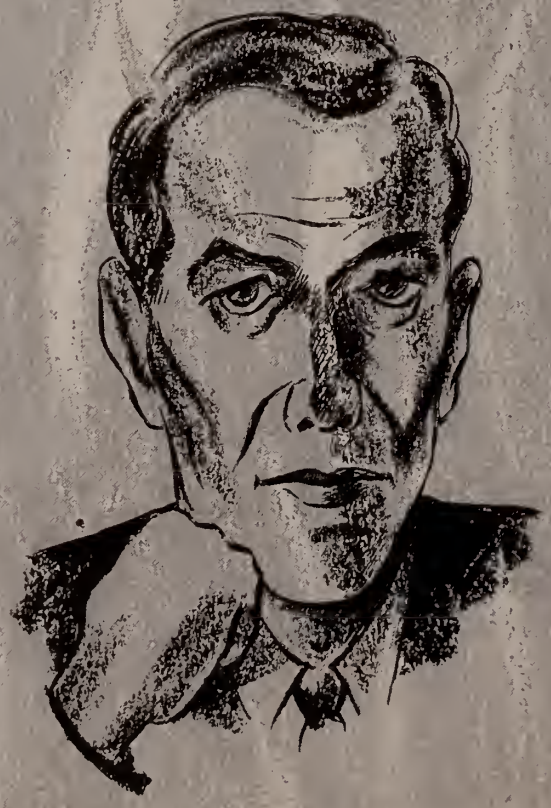
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*TABLETS*






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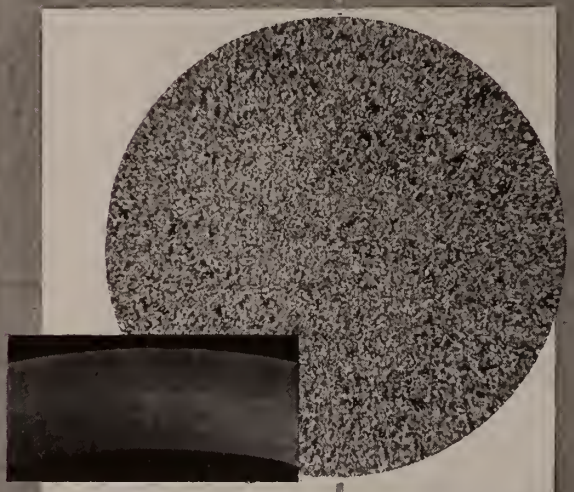
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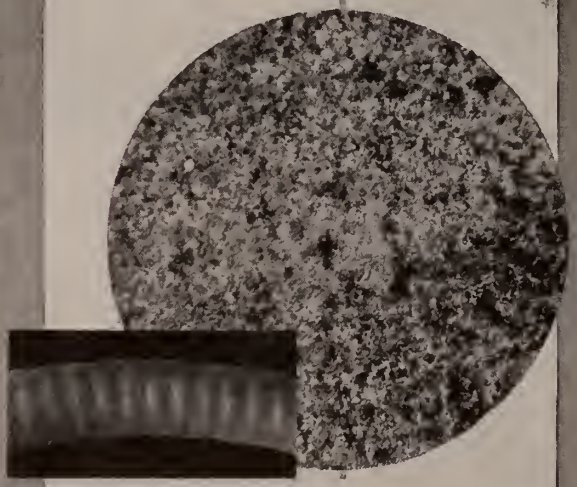
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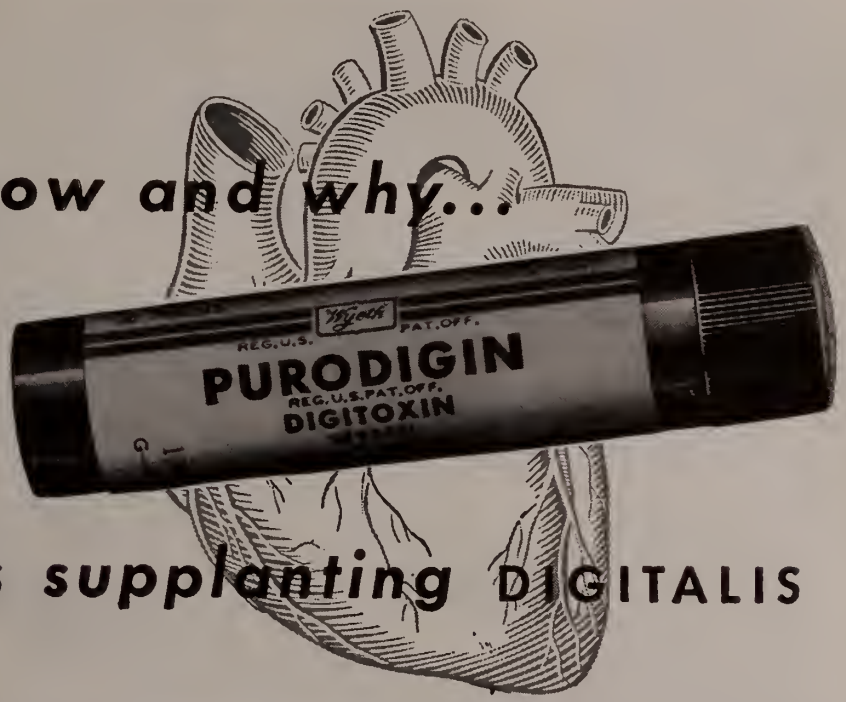
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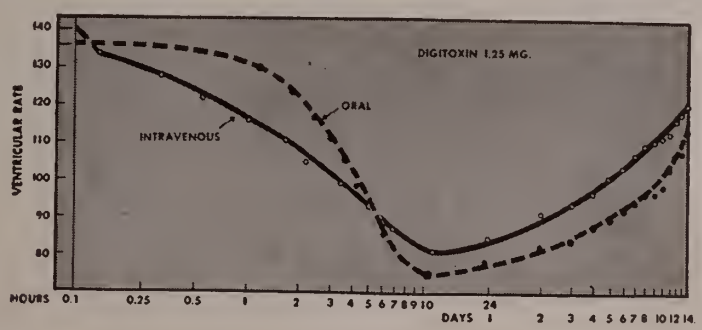
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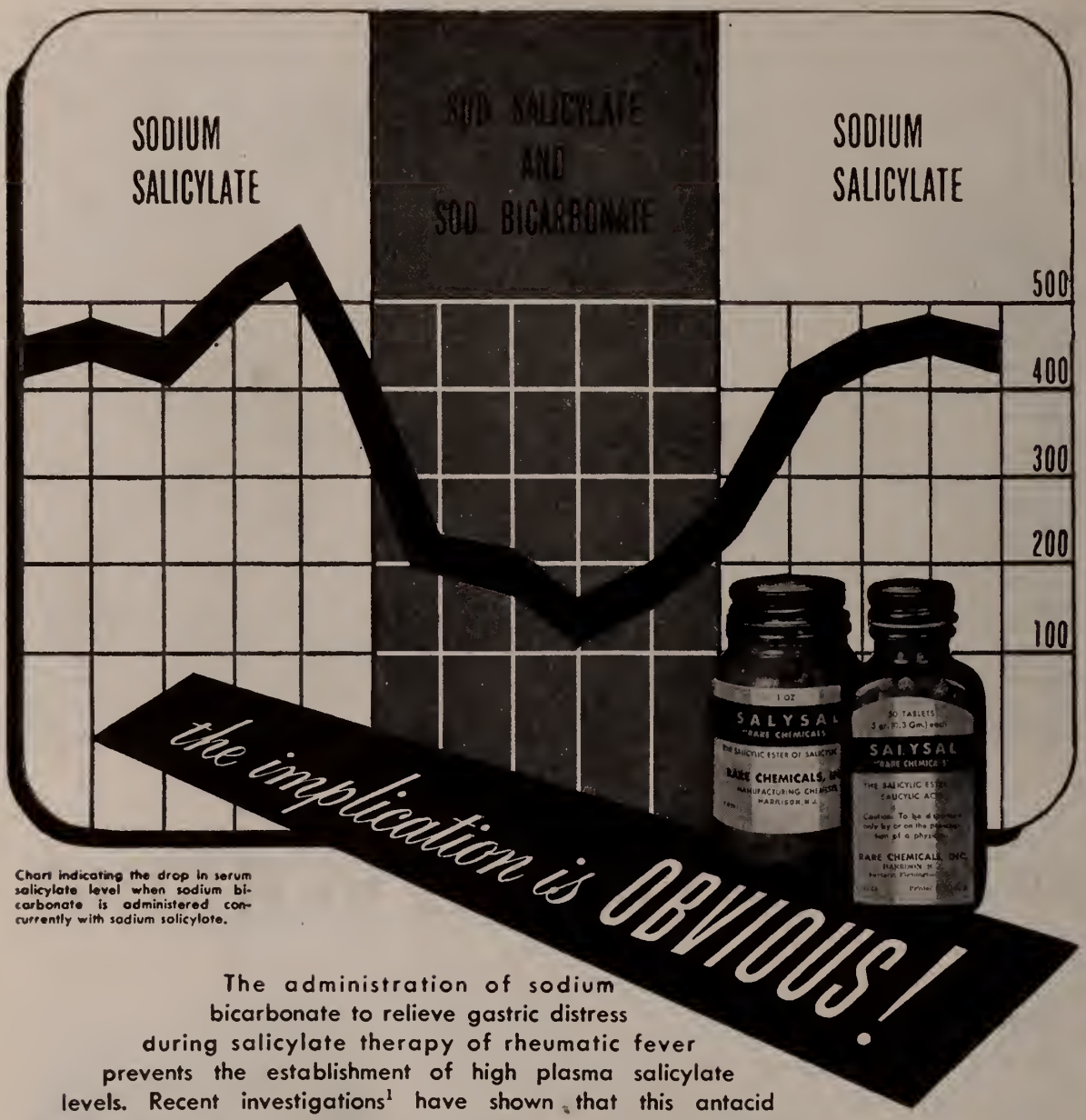



Chart indicating the drop in serum salicylate level when sodium bicarbonate is administered concurrently with sodium salicylate.

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1. Smull, K., Wegria, R., and Leland, J.: The Effect of Sodium Bicarbonate on the Serum Salicylate Level, J.A.M.A. 125:1173 (Aug. 26) 1944.

2. Coburn, A. F.: Salicylate Therapy in Rheumatic Fever, Bulletin Johns Hopkins Hospital 73:435-464, December, 1943

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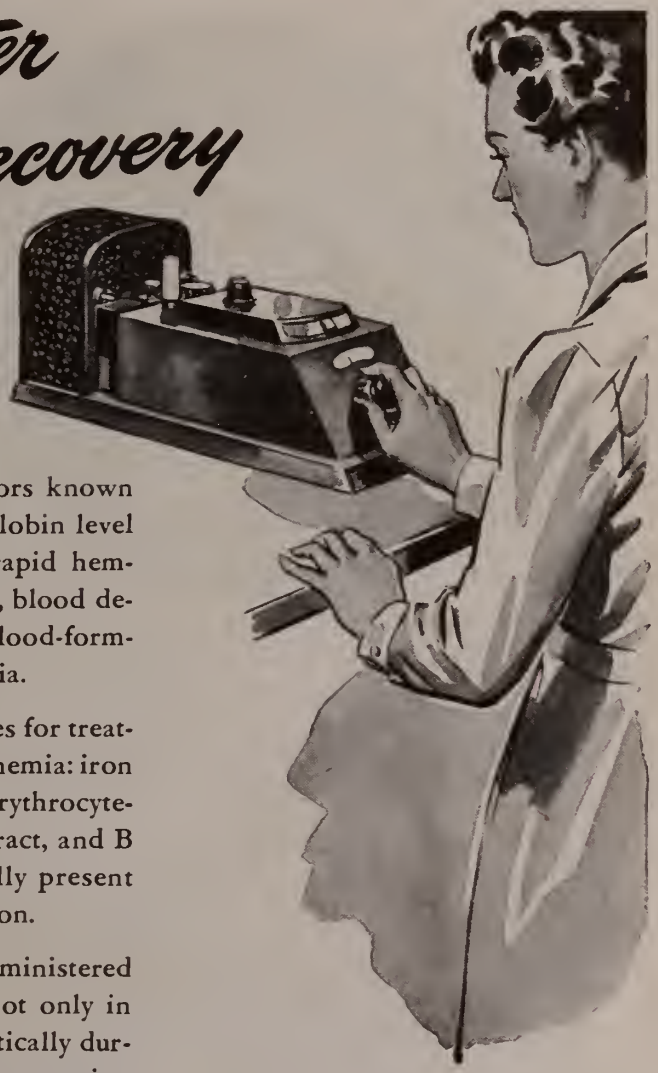
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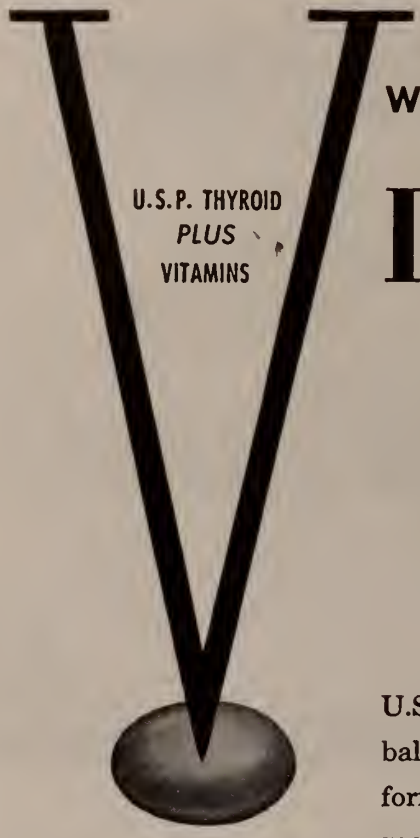
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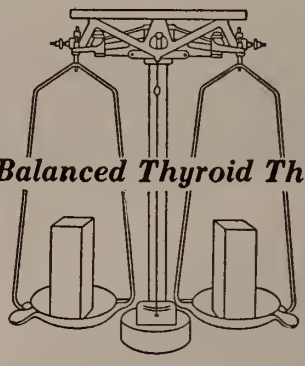

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# *Cause for rejoicing*

BEING subject to the human frailties common to all, the physician must have an occasional day of rest. No occasion could be more fitting than Thanksgiving Day, particularly this year when there is real cause for rejoicing. The guns have now been silent for more than a year. Order has gradually been restored to nations long in chaos. While armies of occupation still must be maintained, much of the danger is over and trips home are more frequent. It is the sincere wish of Eli Lilly and Company that patients may be as considerate this Thanksgiving as their conditions will allow, and that physicians throughout the land may enjoy the day with family and friends.

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*eventually led to the founding of Eli Lilly and Company*

The Illinois Medical Journal

November, 1946

VOL. 90, NO. 5

Official Journal of the Illinois State Medical Society

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# Editorials

## COMMUNITY HEALTH PROBLEMS

For many years it has been the contention of the Medical Profession that health problems can best be worked out through a cooperative program developed and operated primarily on the community level. In operating such a program, it is advisable to enlist the aid of all professional and lay groups interested in community health, as there is work that can be done by all of these various agencies, under medical guidance.

More attention each day is being given to preventive medicine, realizing that many times it is easier to prevent disease than to cure it after disease is actually present. Health departments have an important role in preventive medicine, their primary responsibility, and through a cooperative program carried out jointly by the local health department and medical society, can invariably give the best results.

With the discovery during the past sixty years of most infectious and contagious disease, and utilizing more each year the known methods of successfully preventing and combatting these diseases, there has been a marked drop in mortality and morbidity rates, and an increase in the longevity of the American people. Community groups, or perhaps a Community Health Council, can aid materially in bringing to the citizenry as a whole, the importance of immunization campaigns, to actually prevent the development of contagious disease.

Programs of this type can be instituted in both rural and urban communities and can operate equally successfully in both types of communities, especially if the programs are well planned, and the community organizations interested in the health and welfare of their people do their part.

At the present time the greatest killers among diseases are diseases of the heart and blood vessels, cancer, accidents, nephritis, pneumonia and tuberculosis. Tuberculosis formerly was first on the list of causes of death, and as people became more interested in its early detection and management, we have seen it drop to sixth place, and it should be much lower with the present day knowledge concerning the early detection and care of the tubercular patient.

We have seen during the past two decades especially, many nation-wide organizations spring up as "foundations" or "American Associations" developed to aid in combatting many of the most prevalent diseases. These invariably operate under medical guidance, and likewise ask for the cooperation of State and County Medical Societies to successfully carry on their respective campaigns. It is estimated that at least four million American people have some form of heart disease. Diseases of the heart and blood vessels

accounted for 575,000 deaths in the United States in 1944.

Educational work is paramount, it being necessary to begin in the schools and they should carry out educational programs to thoroughly apprise all people of the dangers of disease, and present day means for preventing them. Various types of community organizations, P.T.A., Womens Clubs, dinner clubs, church groups and labor organizations should be enlisted in community health improvement campaigns, and they will become valuable allies in such a cooperative program.

In 1942, the House of Delegates of the American Medical Association approved a resolution urging that every county in the United States develop a county or multi-county health department, to be supervised and controlled entirely by local people, and financed also on a community basis. In 1943, when the Searcy-Clabaugh Bill for the establishment of county health departments was before the Illinois Legislature, the bill was approved by the State Medical Society. Under this bill, passed in 1943, single counties or two or more counties may join together to form a health department. The proposal must be approved by the voters, and it is supported by local tax funds. The sole interest in the State Department of Public Health is to set up standards for the Health Director, who must have had prescribed public health training, or experience.

With two or more physicians and one dentist on the Board of Directors, composed of seven, medical guidance is assured. At this time there are some 15 to 18 county health departments operating in various sections of Illinois, and as many or perhaps more than this number of counties will vote on the proposal at the fall election. In several Illinois local health depart-


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ments, a physician has been selected as President of the County Board of Health.

Health education is stressed as an important function of the county health departments, and immunization campaigns usually get under way within a short time after the department is established. Sanitary conditions, water supplies, sewage disposal, handling of foods and other important matters are part of the duties of the county health unit.

The county health superintendent is not permitted to practice medicine and devotes full time to his many duties, which is proper and encourages the support of the members of the medical profession in the individual communities. With public health nurses attached to the unit, they are able to give much information to young mothers who desire it, and always with the approval of the family physician. Likewise they aid in many ways in the operation of the department.

Within the past month, letters have been sent out by the American Medical Association Bureau of Health Education, urging all state medical societies to approve, or re-affirm previous approval of county health departments, as it is desired that every county in this country have such services available.

Under the supervision of the American Academy of Pediatrics, a nation-wide survey is being made, each state individually being organized, to determine the type of pediatric care which is given in every county. In Illinois this project has been approved by the Illinois State Medical Society, and a professional advisory committee has been named to give all possible aid, and supervise the survey in this state.

Each councilor district in the down-state areas has a pediatrician selected to guide those making the survey within their respective districts, and in Cook County one has been selected from each of the 15 branch societies of the Chicago Medical Society. Every physician in Illinois will receive letters in the near future asking for certain information which should be given promptly to those responsible for conducting this survey.

County health departments have much to do in connection with the suppression of epidemics, and with the desired type of cooperation from members of the medical profession, most epidemics may be under complete control and suppressed within a short time when everyone does his part.

It has frequently been stated in recent years by those favoring government control of medicine, that the farm workers, as well as others in relatively low income groups, fail to receive adequate medical care when sick, and they do not have available to them, modern medical knowledge which would enable them to enjoy better health. With a properly organized community health group, and particularly with a county health department, everyone, regardless of their economic condition, should be able to get this information and likewise through some local arrangement, adequate medical care when ill or following accidental injury.

With the development of community health organizations and county health departments, operated and financed on the community level, it is quite obvious that through cooperative campaigns, health information can be given to all, and the community having such services available, will ultimately be benefitted through the arrangement.

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## THE ILLINOIS INTERPROFESSIONAL COUNCIL

As reported in the last issue of the Illinois Medical Journal, the Illinois State Medical Society has given final approval to the proposed Constitution and By-Laws for this interprofessional group, and has named the two official representatives from this Society on the Council. Wayne B. Slaughter, M.D., D.D.S., chairman of the Committee on Interprofessional Relations, and G. C. Otrich, Belleville, are the two members to serve in accordance with the Constitution and By-Laws recently approved.

Today more than ever before, it is highly essential that all professional groups interested in the health needs of the people of the United States give every possible consideration to the many problems of mutual interest to these groups. At the present time the professional groups instrumental in forming the Illinois Interprofessional Council are the Illinois State Medical Society, Illinois State Dental Society, Illinois Pharmaceutical Association and the Illinois Nurse's Association. It is possible that another group or two may be added later, but

these groups will meet in the near future to outline the work of the Council for the next year.

All being interested in the many health problems of today, they will meet with a mutual interest in these many problems, and endeavor in every way possible to work for a continued improvement in the health conditions of this state and endeavor in every way possible to avoid unnecessary overlapping as would invariably be the case if each professional organization worked independently.

The Constitution and By-Laws, as approved by the Illinois State Medical Society through its Council, as authorized by the House of Delegates are published for the information of the physicians of Illinois who will be interested in the formation of this new interprofessional organization.

## CONSTITUTION & BY-LAWS of the ILLINOIS INTERPROFESSIONAL COUNCIL

### CONSTITUTION:

ARTICLE 1. The name of this organization shall be "The Illinois Inter-Professional Council of Denistry, Medicine, Nursing and Pharmacy.

ARTICLE 2. "The purposes of this Council are: to promote the science and the art of the practice of the aforesaid professions insofar as they affect the progress, the develepment and the practice of the "Healing Arts" in the State of Illinois; to lend support to the program in matters of common interest shared by other health agencies engaged in the control or the eradication of disease that endangers human life; to cooperate with state and government agencies having for their purpose the dissemination of public health information which we believe will improve hygienic standards of living in the State of Illinois."

ARTICLE 3. *Council.* The council shall consist of two representatives from the professions of Dentistry, Medicine, Nursing, and Pharmacy who shall be appointed by the participating organizations for a period of two years.* Each council member shall serve as a representative of his profession until his successor has been duly appointed and qualified.

ARTICLE 4. *Officers.* The officers of this council shall consist of a chairman, a vice-chairman, and a secretary-treasurer elected at the first meeting following the conventions of the various organizations. The officers shall be elected by ballot for a term of one year and shall hold office until their successors have been elected and have accepted the office for which they have been chosen.

ARTICLE 5. *Duties of Officers.* Section 1. Chairman: The chairman shall preside at all meetings of this council and shall perform such other duties as regularly come within the province of that office.

Section 2. Vice-Chairman: In the absence of the chairman, the vice-chairman shall preside and shall perform all duties as regularly prescribed for the president.

Section 3. Secretary-Treasurer: The secretary-treasurer shall attend all meetings of the council, shall conduct the correspondence of the council, shall keep a record of the minutes of all meetings, collect all fees due the council from participating organizations, and perform such other duties as pertain to the office of the secretary. He shall make an annual report to the council, of all moneys received and disbursed, as directed by the chairman.

ARTICLE 6. Meetings. The meetings of this organization shall be held annually and at such other times as the chairman or a majority of the council may deem necessary.

ARTICLE 7. Committees. The council shall have power to establish such committees, standing and special, as are necessary for the proper conduct of the business of the council.

ARTICLE 8. The state may be divided into districts as the council may deem advisable.

ARTICLE 9. Amendments. Amendments to this constitution may be made at any regular session of the council provided that written notice of the amendment has been mailed to each member of the council and the executive offices of each organization represented, at least 30 days prior to the date of the council meeting, and provided that they have the approval of the governing bodies of each of the participating organizations.

### BY-LAWS

1. A quorum shall consist of a majority of the members of the council with each of the participating organizations represented.

2. Funds. The funds of the council shall be raised by an equal appropriation from each of the participating organizations. These appropriations are subject to the approval of the executive officers of each participating organization. All disbursements of this fund shall be authorized by a majority vote of the council.

3. Amendments. The amendments of the by-laws of the Inter-Professional Council may be made by a two-thirds vote of the council and provided that they have the approval of the governing bodies of each of the participating organizations.

The physicians of Illinois will be very much interested in the work of the Council, and following the organizations of the Council itself, we shall from time to time publish abstracts in the Illinois Medical Journal, of the transactions and stress especially the high lights for the information of our members.

*The first appointment of the representatives made after the adoption of this constitution and by-laws shall designate a member to be appointed for a term of one year and one for a term of two years in order that an alternating sequence of representatives may be affected.

## MENTAL HYGIENE

A. Levinson, M.D.
CHICAGO

Mental hygiene has until recently been looked upon by many physicians as belonging to the realm of psychiatric social workers. This attitude is being changed constantly. Physicians have begun to realize the importance of mental hygiene in every day practice. Mental prophylaxis, it is agreed, should start with early infancy, when psychological conflicts arise by the transfer of the baby from a quiet hospital atmosphere to a busy household, and an overwhelmed mother. Many of the psychological problems in adult life reflect the mental attitude of the individual during his infancy and childhood.

The American Medical Association has recently taken official cognizance of the importance of mental hygiene by requesting the State Medical Associations "to take the lead in the development of an adequate statewide mental hygiene and mental disease program and to cooperate with other groups in stimulating public support in order that sufficient funds may be secured for the public operation and maintenance of such acivities."

The Illinois State Medical Society has for several years had a standing committee on mental hygiene which dealt with various phases of the subject. The committee which consists of pediatricians, psychiatrists and the director of the mental hygiene society of Illinois is very active. It concerns itself with all phases of work for both the prophylaxis of mental diseases and the management of the mentally handicapped. It works hand in hand with existing society for Mental Hygiene of Illinois. It cooperates with the superintendent of public instruction of the state and is trying to get better housing and better instructions for those children who have suffered either cerebral hemorrhage or cerebral anoxia at birth or from some cerebral agenesis but are educable. The committee desires to call on the physician of the state not to be satisfied with a mere diagnosis but to give better care to those unfortunates. As early as 1939 the committee on Mental Hygiene of the Illinois State Medical Society recommended the esablishment of a farm colony on the cottage plan where borderline cases of mental handicap can be returned to society with safety and become useful self-supporting citizens. With this in mind, a bill has been prepared under the auspices of a committee and acted upon in the Illinois state legislature.

The interest in the mentally handicapped children is only a part of the work of the Mental Hygiene committee. Its activity encompasses all phases of prevention of mental disease both in children and adults. The committee hopes to arouse the interest of the practising physicians of the state to this important medical work.

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## "FROM A MISSION TOWER"

From the Bishop of the Diocese of San Diego, California, comes words in praise of medicine. A clipping from the publication of the Diocese was sent to the President of the Illinois State Medical Society, and the permission to reprint was exended us graciously, "either in whole or in part".

Words of encouragement, words of praise have fallen so seldom during recent months packed so full of rumbles and reverberations relative to the socialization of medicine, the Wagner-Murray-Dingell type legislation, and the bureaucratic attitude toward the profession, that it is the opinion of the editorial board that this material should be presented to the members of our Society in full.

We quote, and the article which follows, speaks for itself:

Last November in a special message to Congress President Truman outlined a plan for universal health service which would be regulated and partially subsidized by our federal government. Legislation which would reduce the President's plan to a practical program was ready at hand for submission to Congress as soon as the President's message had been read in both Houses. On the same day that the President's message was released identical bills were introduced in the Senate and the House which would have given the President's health plan the sanction needed to make it a legal instrument binding on all the people of the country. The bill taking its name from its sponsors, is known as the Wagner-Murray-Dingell Bill.

### INTEGRAL PARTS

The President's program, as outlined in his message to Congress, and the Wagner-Murray-Dingell Bill could not be judged separately. They are integral parts of one whole. The bill was drawn up with the approval of the President and it incorporated in practical legislation his ideas for universal health insurance.

After the unhappy experiences of the Wagner-Murray-Dingell Bill in the Senate and the House it might be thought that the whole incident was settled and that the American people could forget about it.

## WILL STAGE A COME-BACK

That would be a mistake. The proponents of the bill consider its defeat as a temporary setback and do not accept its repudiation by Congress as a permanent defeat. There is no reason to believe that the President has changed his mind. There is every probability that a bill similar to the Wagner-Murray-Dingell Bill will be submitted to Congress when it convenes for its next session early in January. Now is the time for the American people to study this health program. Its practical consequences should be anticipated; some of these consequences are possibilities, some of them are probabilities and some of them are certainties.

## CONSEQUENCES

In judging a health program, any person with a minimum of common sense will endeavor to determine what effect it will have on the medical profession. We have become all too familiar with the type of propaganda which our government has used in popularizing revolutionary programs whose fundamental purpose is the concentration of power in the federal government.

## SUSPECT

There is a specious appeal to the general public with rosy promises which are impossible of fulfillment. There is a vicious attack on minorities, whose rights are threatened by these programs. And there is an appeal to the dishonest impulses of the majority which invites this greater number to ignore or deny the rights of the minorities which will be suppressed by these programs.

## DESTRUCTIVE

Direct and indirect government propaganda supporting President Truman's health program will question and sometimes condemn the motives of the medical profession. It will endeavor to persuade the American citizen that his doctor has no right to the free practice of his profession. That right has always been recognized in civilized society up to now. Out of the Soviet Union, however, has come a great light. For the greater need of the greater number, we are urged to approve legislation which will destroy the present position of the medical profession as an honorable and independent calling in a democratic society and which will reduce the man of medicine to the status of a hired hand. The President stated but did not prove that his plan is not socialized medicine. Does the President believe, too, that his plan will not socialize the medical profession?

## "HONOR THE PHYSICIAN"

What happens to the medical profession is of vital concern to every citizen of this country. In protecting his doctor from legislation which will injure the doctor the prospective patient is protecting himself. In speaking of his doctor the average man is usually talking about the general practitioner, the family doctor. What will happen to the relationship which exists under our present system of the free practice of medicine if that system is superseded by state control of the medical profession?

## PERSONAL RELATIONSHIP

That relationship as it exists at present is personal, intimate and independent on both sides. The future of that relationship, if President Truman's health plan became law, can be foreseen by anticipating what would happen to the doctor who was forced to practice his profession under government supervision. The doctor would become a paid employee of the government and in time would lose all realization of the fact that he is a servant of the sick. He would soon come to know that he was not responsible to his patient but to the government whose paid servant he had become.

## TRADITIONS ARE SACRED

A younger generation which had been trained to accept government control of medicine would gradually emerge and ultimately take over the profession. The present traditions of the profession would never have been presented to these younger doctors; the ideals which make the practice of medicine a profession rather than a business would be dismissed by these younger men as outmoded and unimportant.

## A LA BUREAUCRATIC

As the attitude of the doctor toward his patient changed so would the attitude of the patient toward his doctor change. The patient would come to think of his doctor as the representative of a government bureau. The existing relationship which obtains between the doctor and his patient would begin to deteriorate as soon as the medical profession was placed under government control. Ultimately and inevitably it would be destroyed.

## A HUMAN THING

People are well satisfied with the present relationship between doctor and patient. They would find the relationship which followed government control of the practice of medicine intolerable. In the months to come they will hear much of the abuses which occasionally occur in the natural relationship of the doctor and the patient. Abuses there are and abuses there will continue to be. There always will be abuses in any relationship involving human beings.

## ANOTHER THREAT TO FREEDOM

There are abuses in the relationship which exists between husband and wife. We do not, therefore, invite the government to regulate the intimate details of married life and finally to destroy marriage as an institution. President Truman's suggestion that the American people deliver their sick and their doctors to government control would certainly result in the disappearance of the present relationship between doctor and patient. That suggestion should be condemned as an unwarranted reflection on the medical profession and a threat to the freedom of both the doctor and his patient.

# Correspondence

## SEMINAR IN CLINICAL ELECTROCARDIOGRAPHY

St. Bernard's Hospital plans to give a seminar in Clinical Electrocardiography for members of its staff and St. George's Hospitals. This will consist of a series of one hour lectures and demonstrations given in St. Bernard's library on Wednesdays and Fridays from 10 to 11 A.M. during the months of November and December.

This will be a simple orientation course for practitioners and interns to acquaint them with the fundamental elements of Clinical Electrocardiography. The course will be conducted by H. F. DeFeo B.S., M.S., M.D. Assistant Clinical Professor of Medicine Loyola University and Cardiologist St. Bernard's hospital. Physicians from other hospitals are cordially invited to attend.

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## NORTH SIDE BRANCH OF THE CHICAGO MEDICAL SOCIETY

The programs for future meetings have already been worked out, as follows:

December Meeting

"The Methyl Group and Cirrhosis of the Liver" by Dr. Stanley P. Reimann, Director Research Institute, The Lankenau Hospital, Philadelphia.

"The Applications of Vaginal Hysterectomy" by Dr. V. S. Counseller, Head. Section on Surgery, Mayo Clinic, Rochester.

February Meeting

"The Use of Anticoagulant Therapy in the Treatment of Diseases of the Heart and Blood Vessels" by Dr. Irving S. Wright, Associate Professor of Medicine, Cornell University Medical School, New York.

April Meeting

"Nutritional Deficiencies" by Dr. John B. Youmans, Dean, University of Illinois, College of Medicine, Chicago.

There may be one or two additions to this list of speakers, but those listed have already agreed to appear.

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## IOWA AND ILLINOIS CENTRAL DISTRICT MEDICAL ASSOCIATION

To The Editor: —

The quarterly meeting of the Iowa and Illinois Central District Medical Association was held in the Blackhawk Hotel, Davenport, Iowa, Thursday evening November 7, 1946. Dr. H. P. Miller of Rock Island, Illinois, gave a short address on "Diagnosis and Treatment of Phlebothrombosis". The guest speaker was Dr. Francis D. Murphy, professor of medicine at Marquette University, Milwaukee, Wisconsin, who delivered an address on "Chronic Nephritis".

sincerely yours,
James Dunn, M.D.,
501 First National Building
Davenport, Iowa.

## ILLINOIS PROFESSOR HEADS BUREAU OF MEDICAL ECONOMIC RESEARCH

Frank G. Dickinson, Ph.D., associate professor of economics at the University of Illinois, Champaign-Urbana, and widely known insurance consultant, has been appointed economist, Bureau of Medical Economic Research of the American Medical Association. He fills a position vacated by the retirement of Rosco L. Leland, M.D., who had served as director since the bureau was organized in 1931.

George F. Lull, M.D., secretary and general manager of the A.M.A., who announced the appointment, said that Dr. Dickinson has taken a year's leave of absence from the university to accept the position of economist.

Dr. Dickinson began teaching at the University of Illinois in September 1921, and has been in the department of economics continuously except for one year—when he was an instructor at Pennsylvania State College, State College, Pa., where he received his A.M. degree in 1923. He received his A.B. and Ph.D. degrees at the University of Illinois.

Dr. Dickinson gained wide renown in the sports world in 1924 when he developed a mathematical sytem for rating football teams. He worked out his formula as a hobby, but it grew to such proportions that he was compelled to give it up at the end of the 1940 season when the University of Minnesota was given permanent possession of the Rockne Memorial Trophy, sponsored by Notre Dame's 1924 Four Horsemen. Dr. Dickinson said he never commercialized his ratings because "the rating of football teams was my hobby and because of the amateur spirit of college football."

Dr. Dickinson served as president and secretary-treasurer of the American Association of University Teachers of Insurance, consultant to the Illinois Insurance Code Commission in 1934 when it prepared a preliminary draft of the insurance code for the Illinois General Assembly, and as pension and statistical consultant to many corporations. He has written on a wide range of economic subjects for scientific and popular journals. Two of his articles, dealing with the social and economic problems resulting from the declining birth rate, the increasing length of life and the consequent shift toward higher ages of the American people, appeared in the Saturday Evening Post.

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## CHICAGO UROLOGICAL SOCIETY

Dear Members and Friends:

Plans for the coming year were outlined at a meeting of the Executive Committee and Officers in July, 1946. Again the Palmer House offers the most centrally located facilities.

Four meetings were planned for the year: October 24, 1946, January 23, March 27, and May 22, 1947. It is expected to have morning clinical sessions at various hospitals and schools with papers in the evenings, preceded by social and dinner hours.

The Annual William T. Belfield Memorial Lecture was delivered at the October meeting by Dr. Hugh J. Jewett of Johns Hopkins. His subject was a rather comprehensive study of bladder tumors which has been in progress for a number of years.

Applications for new members are again being accepted, having been suspended during the war. Every qualified young urologist in the Chicago region should be a member of the Chicago Urological Society.

James W. Merricks, M.D., *Secretary-Treasurer.*
104 South Michigan Avenue
Chicago 3, Illinois.

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## DERMATOLOGISTS TO MEET IN CLEVELAND

The fifth annual meeting of the American Academy of Dermatology and Syphilology is scheduled for Cleveland, Ohio, from Saturday, December 7 through Thursday, December 12, it is announced by Dr. Earl D. Osborne, secretary of the Academy, 471 Delaware Ave., Buffalo, N.Y. This will be the first meeting of the group since December, 1941, and it is expected to attract more than 1000 members, according to Dr. Osborne.

The principal sessions will be held at the Statler hotel with daily symposia at the Allerton hotel and teaching clinics at Cleveland City hospital Monday, Tuesday, and Wednesday of the convention week. There will be an extensive scientific and commercial exhibit held in connection with the meeting, which will feature special

lectures by members of the Academy and by famed authorities in such other fields as atomic energy, radiology, and surgery.

Most special lectures, special courses and symposia will be presented on the first four days of the week, beginning December 9.

Subjects for symposia will include pharmaceutical therapy, syphilis, X-ray and radium therapy, hormones in dermatology, physical therapy, diagnosis and treatment of ringworm, dermatopathology round table, physiology and chemistry of the skin, allergy, and the psychosomomatic factor in skin diseases.

Officers of the Academy are President Dr. George M. MacKee, New York City; Dr. Everett C. Fox, vice president, Dallas, Texas; Dr. Clyde L. Cummer, treasurer, Cleveland, and Dr. Earl D. Osborne, secretary, Buffalo, N.Y.

## METROPOLITAN LIFE HAS HEART PROGRAM

Interest in the control of heart disease is currently being enhanced by the efforts of many professional and lay groups. This attention to heart ailments had long been warranted. The public is becoming more acutely aware of cardiac hygiene than ever before — a growing interest that should be cultivated and guided with judgement as well as vigor.

During the past third of a century, the improvement in mortality from heart disease was most pronounced in the younger age groups and decreased progressively with advance in age. The death rate from diseases of the heart and arteries, corrected for the ageing of the population, dropped virtually 30 percent between 1911-15 and 1940-44, according to experience among the Industrial policyholders of the Metropolitan Life Insurance Company. This reduction in mortality from the principal cardiovascular-renal diseases has been particularly marked among white females — 37 percent in the above-mentioned period. Among the males, the decrease in mortality, while not as marked as among the females, was 25 percent, still a quite substantial reduction. This still leaves much to be desired in the field of early diagnosis and immediate initiation of adequate cardiac regimes in order to reduce to a minimum incapacity and mortality from these conditions. Concentration of effort must now be placed on teaching the public what is known about prevention, early recognition, and care of cardiac lesions.

In order to assist in the attainment of this goal, the Metropolitan Life Insurance Company is conducting a special campaign on heart disease during the fall and winter months. At that time, the Company's more than 20,000 Field Representatives, in cooperation with official and voluntary agencies, will reach the homes of millions of policyholders with a recent published pamphlet, Your Heart, developed in cooperation with the American Heart Association. A lay education film on heart disease is also being prepared. Distribution will be made to physicians of a packet in which will be included material of special interest to doctors, and a scientific exhibit on heart disease, first shown at the A.M.A. meeting in San Francisco, is available for State and local professional meetings.

Cancer control is a major health problem in the United States. As such, it merits attention not only in programs of research, but also in programs of education. Instruction concerning the nature of cancer and known methods of prevention and control should be included in the high school course of study, along with other important health problems facing the American people today. High school students are interested in such information. Scientific facts should be taught to them so that fears may be allayed, intelligent action as future adults be promoted, and families favorably influenced by the information which students relay to adult relatives.

# Original Articles

## MODERN TREATMENT OF HEART DISEASE AN INDICATOR OF THE CHANGING TRENDS OF MEDICAL PRACTICE

HAROLD C. LUETH, M.D.

Dean, College of Medicine, University of Nebraska

OMAHA

The modern treatment of heart disease differs from that in the past in that it requires a closer coordination with many ancillary medical services and in that respect is an indicator of the changing trends of medical practice. There have been valuable additions to our scientific understanding of heart disease. Intensive salicylate therapy, sulfadiazine prophylaxis, and new methods of reducing dust in the sick room have combined to make the treatment of rheumatic fever more satisfactory. Coronary thrombosis and arteriosclerotic heart disease are problems of increasing importance as more of the the population of the country is living to older ages. Health departments, through the activities of the epidemiologist, the preventive medical officer, the visiting nurse, the laboratory worker, and others have done much to reduce infectious diseases and thus minimize the serious hazard of rheumatic fever. The attention of the public has been directed to the nature, causes and extent of heart disease by physicians, medical societies, special groups, insurance companies and even the Congress of the United States. There is a greater public awareness of the seriousness of heart disease and of the objectives of its treatment than ever existed before. All of these factors have combined to give an indication of the present trends of medical practice.

A consideration of the heart enters into almost every medical or surgical problem. Disorders and diseases of the heart are recognized by nearly all physicians as important features of medical practice. A review of the two most common diseases of the heart encountered in the young and in the elderly will be given.

Progress in the prevention, diagnosis and treatment of heart disease has changed the character of medical practice in the last forty-five years. In 1900 there were 1,755 deaths from all causes per 100,000 population. The twelve principal causes of death in order of frequency were:

| | | |
|---|---|---|
| 1. | Pneumonia | 180.5 |
| 2. | Tuberculosis | 180.4 |
| 3. | Diarrhea and Enteritis | 133.2 |
| 4. | Heart Disease | 111.2 |
| 5. | Nephritis and Bright's Disease | 89.0 |
| 6. | Apoplexy | 67.5 |
| 7. | Cancer | 63.1 |
| 8. | Old Age | 50.4 |
| 9. | Bronchitis | 45.4 |
| 10. | Diphtheria and Croup | 43.3 |
| 11. | Meningitis | 40.9 |
| 12. | Typhoid Fever | 35.9 |

In marked contrast are the latest available figures published by the United States Department of Commerce, Bureau of Census, Vital Statistics for the United States in 1944:

Read before the Post-Graduate Conference of Central Illinois Physicians at Bloomington, June 20, 1946.

*NUMBER OF DEATHS AND RATES FOR THE 10 LEADING CAUSES OF DEATH UNITED STATES, 1944

| | |
|---|---|
| 1. Diseases of the heart | 315.4 |
| 2. Cancer and other malignant tumors | 129.1 |
| 3. Intracranial lesions of vascular origin | 93.7 |
| 4. Nephritis | 69.2 |
| 5. Pneumonia (all forms) and influenza | 61.7 |
| 6. Accidents excluding motor-vehicle accidents | 53.5 |
| 7. Tuberculosis (all forms) | 41.3 |
| 8. Diabetes mellitus | 26.4 |
| 9. Premature birth | 25.0 |
| 10. Motor-vehicle accidents | 18.3 |

A sharp decline of deaths from infectious diseases occurred from 1900 to 1935, while there was a steady rise of deaths from degenerative diseases over the same period.

Physical examination of Selective Service registrants during the recent war gave a representative cross section of the health of the young men of the country. From April 1, 1942 to December 1943 there were about 10,000,000 men examined, of whom 6,400,000 were accepted for military service and 3,600,000 were rejected. Among the first nine million studied the following defects were observed:

| April 1942—March 1943 | | April 1943—Dec. 1943 | |
|---|---|---|---|
| Mental Diseases | 12.5 | Mental Diseases | 17.9 |
| Mental Deficiency | 10.7 | Mental Deficiency | 14.2 |
| Syphilis | 9.4 | | |
| Musculoskeletal | 9.3 | Musculoskeletal | 8.9 |
| Cardiovascular | 8.8 | Cardiovascular | 7.0 |

There were some changes in the standards for acceptance into the armed forces late in March 1943, and the two sets of figures show the differences. In the period prior to March 1943, of the cardiovascular conditions that were responsible for non-acceptance for military service, arterial hypertension was the most common cause for rejection. The defect was frequently encountered among the Negro race and was an important cause for rejection. By April 1943 valvular heart disease slightly outweighed hypertension as the most prevalent specific defect within the group. Rheumatic fever and tachycardia were less frequently encountered and hence were not as common causes for rejection.

Youthful hypertension must be considered as an important feature of current medical practice. Alvarez found that 20.7 per cent of male and 2.7 per cent of female college students presumed to be healthy had elevated systolic blood pressures. Later Drs. Diehl and Sutherland, in a careful study of a large series of college students, found that 5.6 per cent of healthy male students had transitory or permanent hypertension. The physician must carefully examine all patients with juvenile hypertension to determine the extent of the disease. Careful laboratory tests such as the 15 minute phenolsulphonphthalein test, a satisfactory 12 or 20 hour concentration test of the urine, a study of the urinary sediment, blood chemistry studies and, if available, urea clearance tests are clearly indicated so that the extent of the damage can be appraised. An examination of the retinal vessels often yields valuable information in regard to the degree of vascular damage present.

Successful treatment of hypertension in young individuals depends to a large extent on proper diagnosis. Hyperthyroidism, obstruction to the urinary tract, primary renal disease, coarctation of the aorta, tumors of the adrenal and pituitary gland, arteriosclerosis and periarteritis nodosa must be considered in the differential diagnosis. Essential hypertension or an elevation of blood pressure from unknown cause will probably constitute more than four-fifths of all cases.

There is at present no entirely satisfactory method for the treatment of essential hypertension. A number of drugs have been suggested. Nitrites have long been popular to reduce blood pressure during critical periods. Nitroglycerine tablets of .3 to .6 mg. (gr. 1/200 to gr. 1/100) are often given every 2 to 6 hours to protect the patients against episodes of acute vascular crises. Erythrol tetranitrate and manitol hexanitrate are believed by some to have a more prolonged and lasting effect. Our experience has not borne out this contention, and we favor the use of nitroglycerine even though its effects are transitory.

Potassium thiocyanate (gr. ii to giv) Gm. 0.12 to 0.25 (gr. ii to giv) given either as capsules, tablets or preferably combined with elixir three bromides have exerted a very steadying influence on blood pressure. The thiocyanate blood level must be followed as the drug is being given. Determination of thiocyanate levels is a fairly simple procedure and can be carried out in most hospital laboratories. A sample test kit is available on the market so that some physicians determine

*Vital Statistics — Special Reports, Volume 24, Number 1, May 10, 1946.

thiocyanate levels in their offices. Best results are obtained when levels of 6-12 mg. per 100 cc. of blood are maintained. Higher concentrations are frequently accompanied by listlessness, drowsiness, confusion, transient aphasias; lack of muscular coordination, cardiac enlargements, and signs of congestive failure. Thiocyanates are valuable drugs in the treatment of hypertension, but their use must be carefully supervised and the patient frequently re-examined.

Suggestive evidence has recently been presented indicating vitamin K and related compounds (quinones and related diketones) are useful in the reduction of blood pressure. Experimental work by Bing and others showed the injection of amino acids into the ischemic kidneys of cats produced renal hypertension. A theory was propounded that held hypertension as the end result of impaired deaminization of amino acids, the subsequent accumulation of the amino acids in the blood stream and finally the production of renal damage. Vitamin K and associated compounds inactivate toxic amines. All of the work is still in the experimental stage and will require further investigation before a final statement concerning its value can be given. Treatment of human hypertension with renal extracts must be regarded for the present as purely an empirical procedure.

Sedatives have frequently been given to patients with hypertension. All are familiar with the quiet and calm that sedatives frequently give to the high strung and tense hypertensive patient. Adjustments in working hours, conditions of work, home and other situations very often are powerful adjuvants to the successful treatment of high blood pressure. Teaching the alert, anxious patient how to relax is often one of the most important aspects in the treatment of hypertension. Psychotherapy is of real value in an understanding and treatment of some of the minor conflicts that play an important part of the disease. It is probable that the psychiatrist will be called in more frequently in the future than he was in the past for the proper handling of these cases.

Surgical attempts have been made to correct the hypertension found in younger individuals. There are several different operations, and each author claims good results from his procedure. Peet recommends a bilateral supradiaphragmatic sympathectomy; Adson, a bilateral subdiaphragmatic extraperitoneal resection of the splanchnic nerves, celiac ganglions and two upper lumbar sympathetic ganglions; and Smithwick, a thoracolumbar sympathectomy. The best results are obtained only when careful laboratory studies of patients are made prior to the operation. A lapse of a considerable period of time is needed before a fair appraisal of the results of the surgical treatment of hypertension can be given.

Rheumatic fever has long been an important cause of heart disease. The exact incidence of the disease is difficult to estimate since it is not universally reportable. It is believed that much would be accomplished if the disease were more reportable. The epidemiologist would have additional data from which important studies could be made, thus giving a better insight into the disease and its mode of transmission. Responsibility rests with the medical profession to take the step. Just as the members of the McLean County Medical Society recognized the need for a complete, modern health department and went forward to have the department organized and functioning, it is believed the profession should initiate the steps that would make rheumatic fever reportable.

The McLean County Medical Society is to be congratulated for its part in the organization and development of the Health Department. A health department is really a vital part of the medical activities of a community. Its successful operation depends to some extent on the personnel entrusted with its administration, to some extent on the personnel in its laboratories, to some extent on the visiting nurse personnel, but to a larger extent on the continued and intelligent support by medical practitioners in the area. In a very real sense it is your health department, and its future activities depend largely upon your thoughtful assistance and genuine support. There is nothing new in the support of health departments by the profession. A review of the transactions of the meeting held in New York in 1846 of the National Medical Convention, an organization that one year later became the American Medical Association, revealed the real concern in adequate public health measures by the profession a hundred years ago.

Adequate treatment of acute rheumatic fever consists largely of bed rest, good nursing care, sufficient salicylates and a proper dietary regime.

Effort is directed toward reducing the severe inflammatory reactions in the vascular tissues that are responsible for the valvulitis, pericarditis, and myocarditis. There is no known method of destroying the antigen producing substance that follows an infection and results in the severe damage to the cardiovascular and pulmonary systems. Consequently, all mild and severe sore throats, sinusitis, upper respiratory infections and otitis media should be considered as potential forerunners of rheumatic fever. Any patient with a sore throat who is slow to recover, has a low grade fever and an elevated sedimentation rate must be viewed with suspicion.

Monocyclic and polycyclic joint disease are often the first indications of the disease to the patient and his family and are the conditions generally found by the physician at his first visit. Complete bed rest is imparitive until all signs of activity have subsided. Sedimentation rates and pulse rates have been valuable guides to help judge the cessation of activity. A highly nutritious diet and good nursing care are important factors in treatment. Large doses of sodium salicylate 1.3-2.0 Gm. (gr. xx — gr. xxx) are most effective. Following the work of Smith and Wegria, it appears inadvisable to use sodium bicarbonate with sodium salicylate as it reduces the blood concentration of salicylates. Usually a blood level of 30 — 50 mg. per 100 cc. of blood can be obtained within 24 — 48 hours by the oral administration of sodium or acetylsalicylate in 1.3 to 2.0 Gm. doses every 4 hours. Intravenous administration of salicylates as suggested by Coburn is rarely needed. Toxic effects from salicylates are well known and include tinnitus, gastric distress, excitement, increased irritability, muscle twitchings and burning of the eyes. Sulfonamides have been used by many but the results are not impressive. In the prophylaxis of the disease the sulfonamides have exerted demonstrable effect in reducing the incidence of septic sore throat, acute otitis media, sinusitis and tonsillitis. Penicillin has not proved to be of value in the treatment or rheumatic fever. Digitalis, diuretics, oxygen and quinidine are of value only when congestive failure is present and have no part in the treatment of acute rheumatic fever.

After the patient has passed into the inactive stage treatment assumes new aspects. More physical activity is allowed and the amount should be carefully regulated by the physician. If a skilled physiotherapist is available this phase of the treatment will be easier. Often nurses with special aptitude or training in the field of physiotherapy can do much to help the physician. During the war a reconditioning program was instituted by the Surgeon General of the Army. The program was under the careful supervision of the physician and showed how convalescence could be safely speeded up in most cases of injury and disease. Civilian physicians must more actively cooperate with other workers in related medical fields so as to insure the maximum benefits for the patient. In any program of this type the physician must be the guiding force or abuse in many directions will soon discredit the program.

There has been renewed interest in the problem of rheumatic fever throughout the country, particularly in regard to existing facilities for proper care. Swift estimated there were fewer than a thousand beds devoted exclusively to the care of rheumatic heart disease patients in the United States. One rheumatic heart disease hospital, seven convalescent establishments devoted entirely to the care of rheumatic heart disease, and one unit furnishing foster home care were the entire facilities of the country in 1940. Durand the Navy one large hospital at Corona called the Rheumatic Fever Unit. There is still acute need for additional beds in convalescent hospitals or institutions to care adequately for the rheumatic fever patients. Careful attention must be given to all phases of the problem to insure proper placement of children, good medical care, adequate nursing, satisfactory educational programs, sufficient dental care, scientific dietary management, and a carefully supervised program of physiotherapy. A program of this type will need the closest coordination between the physician and the social worker, nurse, school teacher, dentist, dietitian and physiotherapist.

Physicians have worked with nurses long enough to appreciate one another's point of view. A majority of doctors do not find it difficult to work with a nurse. When the physician takes enough time to explain the situation at

hand and the objectives in treatment, there is usually a better mutual understanding. The public is well aware of the situation and expects the doctor and nurse to get along well together. The dietitian is a more recent addition to the medical staff and she is not as fully or as completely understood by most physicians. However, when dealing with metabolic diseases, diabetes mellitus, gout, thyroid disease, peptic ulcer or digestive diseases the physician soon becomes aware of the tremendous assistance the dietitian can give. There has been good understanding and mutual trust between physicians and dentists. Physiotherapy is also a recently developed specialty and the profession as a whole has been slow in accepting its help. When the physician treats a patient with muscular disorders, poliomyelitis and rheumatic fever, and is fortunate enough to have the services of a physiotherapist, he will soon appreciate the value of physical medicine.

The general social worker is generally looked at with askance by the average physician and it must be admitted the feeling is mutual. It is singular that so many social workers are trained without really coming in contact with the ideals of medicine. Too frequently students are given basic courses in the general social sciences at the various colleges and universities without sufficient orientation of the aims and purposes of the medical profession. It is not surprising that they go to their clinical work and look on the doctor as another technician along with the grocer, landlord or industrialist. Often when consulted by social workers a short explanation of the case and the aims of treatment are helpful. After a short conversation with the doctor many erroneous beliefs can be dispelled and a new viewpoint reached. The profession has been negligent in not cooperating more fully with schools of social science and presenting to them the ideals and objectives of the medical profession. Doctors at times resent the general social worker and fail to offer the assistance they should for the immediate and ultimate benefit of the patient. On occasion general social workers are regarded as plain nuisances. Does the average critic of social workers ever realize the amount of time they save the doctor? During the war we heard many loud complaints because doctors were asked to be sanitary officers, mess officers and supply officers. It is wondered what the critic of the social worker would say if he were assigned her job. It is realized that there may occasionally be warped viewpoints among general social workers as among any group; however, a common understanding can be reached in any group only when both parties fairly and reasonably discuss their problems at the conference table. Social workers as well as physcians often hold fixed opinions about certain matters without being fully informed on all phases of the subject. The general social worker is an invaluable aid to the physician if a proper rapport is reached and a mutual desire kindled to pursue the course that will most benefit the patient.

The University of Illinois has led the way in the development of a training program for general social workers in rural and small urban communities. The present training schedule includes actual case work and supervised field work in family and child welfare. It is contemplated that active hospital and clinical training will be given under competent direction at Research and Educational Hospital within the next year. Graduates of the program should be ideally equipped to work well with doctors in communities like yours.

The medical social worker, a development of the blending of the efforts of the medical profession and the social sciences, has long done valiant service in our hospitals and clinics.

Arteriosclerotic heart disease is one of the most common forms of heart disease. There has been a steady increase in the number of people over 45 years of age in the United States during the past fifty years. Two important causes have combined to produce this effect. In 1900 there were 30 live births per 1,000 population and in 1940 there were 16 per 1,000 population. In spite of striking reductions in the number of acute infectious diseases and remarkable diminutions in the number of deaths in the younger age groups, the fact remains that fewer children are born today compared to 1900. More people live to old age than ever before. When mortality trends are adjusted for the changing age composition of the population, it becomes apparent that there was a greater decline in mortality during the last two decades of the 1900-1943 period than during the earlier half of the period. It has been estimated that

there were twice as many people over 65 years of age in 1943 in proportion to the total population than in 1900. Some have stated that there are more than ten million people over 65 years of age in the country at present. The magnitude of the problem is readily apparent.

Treatment of arteriosclerotic heart disease consists in the use of vasodilator drugs, sedatives for rest and adjustment of the patient's life well within his physical and mental capacities. Aminophylline in 0.1 Gm.-0.2 Gm. (gr. i ss - gr. iii); Glucophylline 0.234 (gr. iv): Theocalcine 0.5 Gm. (gr. vii ss) and Theocine 0.1 Gm. (gr. i ss) T.I.D. are the drugs most commonly used. Sedatives most commonly used are phenobarbital, bromides, seconal, nembutal and chloral hydrate. A diet low in cholesterol is probably as beneficial as any single item. The low sodium diet of Harrison, Grollman, Mason, Baxter, Crampton, and Reichsman might be tried in cases of arteriosclerosis and hypertension.

Adjustment of the patient to a reduced schedule of physical and mental activity is an important part of the physician's advice. For those active in business, professional or commercial work, adjustment to a reduced schedule should be tried. The problems of those engaged in physical labor or women with many household chores are among the most perplexing to the physician. Understanding, tact and patience will accomplish the desired results.

Men and women retired from active life are also real problems. The physician should strive to find some outlet for the physical and mental energy of the retired pensioner. A minor post in a civic, philanthropic club or lodge often gives purpose and aim to life, when idle retirement hangs like a mill stone about the wearer's neck. Often in the midst of a busy practice we have a fleeting thought of the solace of retirement with its freedom from work and worries. Several months of idleness are about all that some active men and women can stand before they are ready for a definite task. Doctors can offer real assistance in helping those still physically and mentally able to do some work find a task that requires enough of their energies to keep them busy without overtaxing their bodies or minds. A skilled social worker may be a valuable aid in suggesting possible sources of employment, either for financial gain or as charitable ventures.

More is being discovered about heart disease continually so that its diagnosis and treatment are constantly changing. During the past fifty years the medical profession has had to put more reliance on the nurse, the dentist, the laboratory worker, the dietitian, the physiotherapist, the social worker and the school teacher to provide adequate modern treatment. Most of the progress has been made when the profession has outlined the broad or even specific directions or programs and allowed the ancillary assistants to work out specific details. The profession itself has long stood for progress in scientific medicine. The Postgraduate Meeting of the Central Illinois Physicians is a concrete expression of the earnest desire of doctors to improve their fund of knowledge. As early as 1766 a meeting of physicians was held in New Brunswick, East New Jersey, and it formed what is believed to be the first medical society in the United States. A constitution was adopted, the preamble of which read in part "(To have) mutual improvement and advancement of the profession, the promotion of public good and the cultivation of harmony and friendship among the brethren." Eighty years later a National Medical Convention was held in New York on May 14, 1846, and they framed the constitution of the organization that is called the American Medical Association. In the original constitution of the American Medical Association the following statement appears: " . . . . must . . . . supply more efficient means than have hitherto been available here for cultivating and advancing medical knowledge." . Gentlemen, by your action in the creation and presentation of the first postgraduate program in Central Illinois you have taken an important step toward the fulfillment of the hopes of the founders of the American Medical Association. You are to be congratulated on your splendid work!

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From time immemorial man has considered health as his rightful heritage, and has therefore resented disease as a misfortune visited upon him by malignant external influences. Edward J. Stieglitz, M.D., A Future for Preventive Medicine, The Commonwealth Fund, 1945.

# PLEMINARY RESULTS WITH A NEW FENESTRATION TECHNIC

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The fenestration operation for improving the hearing in otosclerosis was introduced eight years ago. From a small beginning beset with many failures the operation has developed to a highly refined technic that has been carried out on several thousands of patients suffering from otosclerosis with varying success.

It is vital to the development of otosclerosis surgery that its results be made accessible to all otologists so that the merits of any new techic may be judged in comparison with other technics. To this end we keep a record on a "fenestration score board" of the audiometric results in every operated case, and this score board at the Wesley Memorial Hospital, is open for examination by any otologist. The score board is kept up to date by periodic retesting of every case, several times during the first year after operation, and at least once a year thereafter.

Over the past 8 years my associate, Dr. Arthur Juers, and myself have performed and followed 1,088 fenestration operations. Loss of the hearing improvement has occurred to date in 58. Of these 31 have been re-operated and in every instance bony closure of the fistula was found to be present. Therefore we believe that permanent loss of the hearing improvement after the fenestration operation usually means bony closure of the fistula.

Of the 58 cases that lost their improvement, due presumably to bony closure, 84% lost their improvement during the first post-operative year, and 98% had lost their improvement by the end of the second year after operation. Therefore we we have concluded that osteogenesis causing bony closure of the fistula is most active during the first post-operative year, occasionally it may continue into the second year, but after two years osteogenesis is no longer active and bony closure almost never occurs. The 2 year result of the fenestration operation accordingly may be regarded as the permanent and final result.

Bony closure of the labyrinthine fistula has been the chief obstacle to the surgical treatment of otosclerosis since its inception 50 years ago. The evolutionary development of the fenestration operation has been aimed chiefly at the discovery of improved methods of preventing bony closure. This development has taken several directions. One has been toward the use of metal or cartilaginous obturators to keep the fistula open. Another, pursued at Northwestern University and the Wesley Memorial Hospital has resulted from research studies carried out on the monkey. From these experiments the following factors appear to be important in influencing osteogenesis after the fenestration operation:

1. The sluggish response to trauma of enchondral bone as compared to the periosteal and endosteal layers of the labyrrinthine capsule.
2. The stimulating effect of bone dust and chips on osteogenesis.
3. The stimulating effect of trauma to the endosteum within the labyrinth.
4. The inhibiting effect of skin on osteogenesis.
5. The inhibiting effect of a smooth polished bone surface.

The clinical application of these experimental studies has progressively reduced the incidence of bony closures from 30 out of 108 operations performed during the first 3 years of this work, to 15 out of 388 operations done during the next 2 years, and to 14 out of 570 operations done during the past 3 years.

As the incidence of bony closures has been reduced post-operative serous labyrinthitis has loomed ever larger as the most important cause for failure in our cases. Some degree of labyrinthitis occurs in every patient who has an opening made into the labyrinth, with spontaneous nystagmus lasting a few hours to several days. If the labyrinthitis is severe the hearing becomes depressed and the patient will frequently exhibit the symptom of diplacusis. Depending upon the severity of the labyrinthitis the hearing may recover entirely with an excellent permanent improvement, or there may be little or no improvement, or the hearing may be permanently depressed, even, in rare cases, to complete loss of cochlear function.

Experimental studies on the monkey suggest that post-operative serous labyrinthitis is due more to the escape of serum and blood from the skin flap into the perilymph space than to

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infection of the perilymph space itself. The sequence of events seems to be as follows:

Immediately following the fenestration operation the tympanomeatal skin flap covering the fistula shows a marked reaction consisting of capillary dilatation and increased capillary permeability with the escape of red blood cells and serum into the connective tissues of the flap and into the perilymph space at the fistula. This reaction is, we know, due to the liberation of histamine and histamine-like substances from the traumatized soft tissues. By the fourth day the capillary dilatation begins to subside and the skin flap thickened by the accumulation of red blood cells and serum, begins to return to normal. In the perilymph space at the fistula the delicate arachnoid mesh shows a slight to a marked cellular reaction with fibroblasts, lymphocytes and macrophages. This reaction, which we may call an acute proliferative archnoiditis, serves to remove the red blood cells and serum that have accumulated. The arachnoiditis may then resolve and resorb, or if severe, permanent fibrosis may remain in the perilymph space at the fistula, and osteogenic replacement of some or all of the fibrous tissue with bone may occur.

Meanwhile red blood cells and serum gravitate to the cochlea. In the cochlea, however there is no arachnoid mesh in the perilymph spaces of the scala vestibuli and the scala tympani to remove the blood, and the red cells settle in the dependent portions of these ducts where they may be found as long as a month after operation. The endolymphatic system remains free from red blood cells, but the sterile inflammatory reaction at the fistula, and perhaps the presence of stagnant blood and serum against the very thin walls of the endolymphatic duct, cause a serous or fibrinous exudate to accumulate in the ductus cochlearis. If this is slight it may resorb without permanent damage to the organ of Corti, but if severe it leads to an "adhesive degeneration" of the organ of Corti, where Reissner's membrane, the tectoriol membrane and the hair cells become glued together with degeneration of the hair cells.

The problem of the prevention of severe post-operative serous labyrinthitis has narrowed down in our experimental studies to the problem of minimizing the inflammatory reaction of the skin flap, and to the problem of preventing the blood and serum from gravitating to the cochlea.

Two measures have recently been adopted which give promise of partially solving these two problems. These are the use of a head-frame to maintain the cochlea in the operated ear in a position superior to, rather than dependent to the fistula, and the use of elastic, absorbent sea-sponge packing. While it is too early to judge the ultimate effect of the sea-sponge and head-frame technic to minimize labyrinthitis, the early hearing results that have thus far been secured are striking and gratifying. Particularly noteworthy has been the frequent absence of the high-tone drop that we were accustomed to expect during the first few weeks after operation, and which sometimes recovered many months later, but sometimes remained as a permanent further loss for the tones of high pitch.

The rationale of the sea-sponge technic for preventing labyrinthitis is as follows:

The capillary dilatation and increased permeability in the skin flap that causes or contributes to post-operative serous labyrinthitis is due to histamine and histamine-like substances liberated in the skin flap by unavoidable operative trauma. Stagnation of blood in the dilated capillaries tends to prolong and intensify the histamine-effect, while the escape of blood and serum into the connective tissue of the flap further increases the accumulation of histamine as these blood elements break down and are absorbed. Water-proof paraffin or vaseline packs tend to keep escaped serum and blood imprisoned in the cavity against the skin flap, contributing further to the local histamine effect. Moreover, paraffin and vaseline packs fail to provide the constant elastic pressure needed to keep the capillaries squeezed dry. These principles have been known to general surgeons, who have found that elastic absorbent sea-sponge packs maintained with considerable pressure against skin grafts and large wounds result in a marked decrease in the post-operative devitalization of the skin margins and in the post-operative inflammatory edema of the skin.

Applying these principles to the fenestration operation we now place a single strip of plain gauze moistened in Ringer's Solution against the tympanomeatal skin flap. To facilitate the subsequent painless removal of the sea-sponge packs, either a paraffin gauze (Mosher), or a rubber tissue basket, open at the bottom, is placed in the operative cavity. Pieces of sterilized sea-sponge

squeezed out of a suspension of sulfadiazine powder in Ringer's solution are inserted into the basket against the strip of plain gauze covering the flap. The skin incision is sutured and another piece of sea-sponge is inserted under considerable pressure beneath the sutured incision. A final large piece of sea sponge is placed over the external auditory meatus, and dry gauze dressings are applied, piled up over the ear to exert continuous pressure.

This initial dressing is not touched for 6 days. On the 6th day the sea-sponge packs and paraffin basket are removed, the cavity is dusted with sulfadiazine powder, but the plain gauze strip lying immediately against the tympanomeatal skin flap is not disturbed until the 10th day. In this way the skin flap over the fistula remains immobilized for 10 full days. On the 10th day the last gauze strips are removed, and the cavity is painted with tincture of merthiolate, 1-1,000, and is dusted with sulfadiazine powder. On the 14th post-operative day the cavity is painted with tincture of merthiolate and dusted with sulfadiazine powder. On the 21st, 28th and 42nd post-operative days the cavity is painted with 2% aqueous gentian violet, and thereafter not oftener than once a month until it is completely epidermized and healed.

The only deviation from this routine is made in the very rare case that develops a purulent discharge, in which case the ear should be dressed every day or two until the infection has cleared.

The results with this routine on the post-operative course have been to reduce the total number of post-operative dressings before the ear is completely epidermized and healed to an average of about 6.

Especially suprising and striking has been the small amount of drainage from the sea-sponge packs onto the gauze dressings, and the dry character of the sea-sponge packs, and of the cavity, when the packs are removed.

Equally striking and significant has been the absence of coagulated serum in the operative cavity at subscquent dressings after removal of the packs. Frequently we used to find the cavity almost filled with serum and fibrin 2 days after removing the water-proof paraffin or vaseline packs. This change is evidence that the sea-sponge technic is greatly lessening increased capillary permeability in the soft tissues.

The rationale of the head-frame is this. We observed that blood and serum accumulated in the dependent portions of the cochlea in the monkey, due to gravitation. After the fenestration operation the patient prefers to lie on his unoperated ear, placing the cochlea of the operated ear dependent to the fistula. By means of a simple head frame devised by Dr. Charles Whitaker, the resident in otolaryngology at the Wesley Memorial Hospital, the patient can lie only on his back or on his operated ear, so that the cochlea is kept superior to the fistula at all times. The patient is kept in bed for four days after operation, and then is allowed up. The result of this immobilization of the head has been to diminish greatly the degree and duration of post-operative vertigo, nystagmus, vomiting and ataxia. With very few exceptions our patients are now discharged from the hospital immediately following their first dressing on the 6th day after operation.

The hearing results thus far observed with the sea-sponge and head frame technic afford proof of the lessened cochlear damage from serous labyrinthitis. A majority of patients now maintain a definite hearing improvement throughout the post-operative period, where previously a considerable post-operative depression in hearing was observed in the majority of cases, reaching its lowest level about one week after operation.

The ultimate value of the sea-sponge and head-frame technic to lessen labyrinthitis will not be known until the 2 year hearing results are available in a consecutive series of 100 or more cases. It is logical to expect that the reduction in the post-operative labyrinthitis will not increase the frequency of bony closures already reduced to 5% after 2 years, and that the sea-sponge and head-frame technic therefore will result in a substantial increase in the proportion of permanent satisfactory hearing improvements.

CONCULSIONS:

1. The two year hearing results of the fenestration operation may be considered the permanent hearing results.

2. Experimental studies on the fenestration operation in the monkey have brought out certain factors that influence osteogenesis tending to close the fistula. The application of these factors to the human operation has reduced the incident of failure due to bony closure to 5% in cases tested after 2 years.

3. Post-operative serous labyrinthitis has been the most frequent cause for failure since the measures to prevent bony closures were adopted. The escape of blood and serum into the labyrinth from the skin flap appears to be the chief cause for this labyrinthitis. The sea-sponge and head-frame technic for preventing labyrinthitis has resulted in a striking improvement in the early hearing results, and may be expected to improve the permanent hearing results.

4. The new fenestration technic developed at Northwestern University embodies a number of changes from other technics, the most important of which are:

(a) Enchondralization of the fistula.
(b) The use of constant irrigation and the microscope while making the fistula.
(c) Scrupulous avoidance of trauma to the endosteum within the labyrinth.
(d) The sea-sponge and head-frame technic to prevent post-operative serous labyrinthitis.

DISCUSSION

Dr. John R. Lindsay, Chicago: On the basis of my own experience with the fenestration operation in the human I can agree with Dr. Shambaugh that the prevention of bony closure of the fistula is not the only, and possibly not the greatest, factor which contributes to the unpredictability of results. Bony closure of the fistula proved to be an unsurmountable obstacle for many years during which the operation was attempted, but now that this can be overcome with adequate attention to operative technic it has become apparent that a still further difficulty is present in the depression of hearing which usually occurs in the early post-operative period and has been attributed to a form of labyrinthitis.

Dr. Shambaugh attributes this labyrinthitis to exudation and hemorrhage into the labyrinth from the covering flap. The same interpretation was voiced by Lempert two years ago, who claimed to have been able to prevent this unfavorable reaction by the use of the cartilaginous stopple. Experience of others who have used the stopple, however, has not been so decisive.

On the basis of animal experiments (fenestration operation in more than 70 monkey ears) one is impressed with the fact that the interpretation of what is seen under the microscope is not always definite, and different observers may make different interpretations. In my experiments signs of postoperative hemorrhage within the labyrinth have usually been absent and, if present, were limited to the region of the fistula. Histologic alterations affecting the cochlea have been strikingly absent. Theoretically, it seems likely that the depression of function is related to chemical changes occurring in the region of the operative site, but one must recognize that this has not been proven by the animal experiments.

Regarding the two alterations of technic proposed by Dr. Shambaugh, (1) the use of a sea sponge as packing and (2) the use of posture to prevent hemorrhage into the cochlea, I am inclined to think that the use of a sponge is good in principle. It is one of several satisfactory types of packing used in maintaining close contact of the flap to the bony edges, thereby promoting union by first intention without an intervening layer of fibrin into which osteogenic tissue may grow. The most important factor, however, in maintaining an open fistula is in allowing the underlying membranous canal to make contact with the flap, to which it must adhere if the growth of osteogenic tissue between the flap and the canal is to be prevented. A contact between the membranous canal and the covering flap depends upon the natural tendency of the membranous canal to lie at the outer periphery of the perilymphatic space and therefore make contact with the flap.

The theory that pressure on the flap will prevent hemorrhage and exudation of histamine-like or other substances is questionable. When one examines the animal ears, one is impressed with the amount of injury to tissues, particularly the endosteum, which would not be influenced by the type of covering material used. On the basis of both animal and human fenestrations it would seem definite that the less trauma there is to structures within the bony labyrinth the less the reaction that will result. It seems probable that this sterile inflammatory reaction within the labyrinth may be related definitely to the occasional unfavorable effects on the sense organ.

Dr. H. M. Cutler, Chicago. I have enjoyed very much the presentation Dr. Shambaugh has given in outlining a new variation in technic. In observing a great many fenestration cases the remarkable advances made in otology by this operation can be noted as the following: First, remarkable freedom from meningitis in the many cases in which the perilymphatic space had been opened; Second, demonstration of prevention of osteogenesis of the bony labyrinthine structure over long periods of time — as long as five years and more; Third, showing audiometrically a decided permanent improvement in hearing which has heretofore never been shown by any other medical procedure (excluding the hearing aid).

Among the variety of causes for failure one might include lack of selection of suitable cases; osteogenesis, which as Dr. Shambaugh has shown need not exceed 8 to 10 per cent; and labyrinthitis, serous adhesive, granulating and suppurative. I should like to stress the last named, inasmuch as all efforts at present are directed toward reduction of labyrinthitis, by the use of penicillin, the stopple technic, reduction of hemorrhage, locally, systematically and operatively, and the introduction of a fluid, iso-osmotic and with a Ph of perilymphatic fluid. It is apparent, however, that up to this time adequate investigation into this vital problem has not been forthcoming.

In the past 32 cases upon which I have operated, the labyrinthine symptoms were closely studied and recorded. Both immediate and late findings of importance were noted. Briefly, a few items may be mentioned, such as the type, degree, direction of nystagmus which, interestingly enough, is just the opposite to that in which fistulae occured as a result of injury. Remarkable is the occurrence of the vascular fistula sign and the vascular head nystagmus.

Also, in respect to the fistula sign, typically in the fenestration operation the reaction is toward the operated ear on compression and a reversal and weaker reaction on aspiration to the unoperated side. However, interestingly, some cases have shown reversal and atypical reaction on the aspiration component of the fistula sign. It is our belief that the accurate investigation of these symptoms may lend value to the scientific approach of the operation and may be of prognostic importance, and I would suggest that evaluation of these symptoms be added to our appraisal of results.

Dr. George E. Shambaugh, Jr., Chicago (closing): I want to thank Dr. Lindsay and Dr. Cutler. Dr. Lindsay mentioned the adhesion of the endolymphatic labyrinth to the skin flap as helping to hold the fistula open. By making the fistula on top of a mound, as healing occurs the skin flap tends to contract and adhere more closely to the membranous labyrinth. Concerning the use of the stopple: this was first described two and a half years ago. It is unfortunate that it should have been publicized in the lay press before its value had been proved. My own experience with the stopple has been disappointing. We used it in eight cases; one had a dead cochlea; the others had some improvement, but slightly less than other cases in which it was not used. From what I understand it is being gradually abandoned. At least until the two year results are publicized, I do not think we can conclude that the stopple is an advantage, either in keeping the fistula open or in preventing labyrinthitis.

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The problem of infection in tuberculosis is simplified by the fact that healthy carriers of the organism, comparable to diphtheria carriers, are unknown. Between one-half and two-thirds of the population carry evidence of infection with tuberculosis, but in few does the disease give rise to a lesion which releases tubercle bacilli. Occasional patients with chronic fibroid phthisis in whom the disease has reached an equilibrium may, to be sure, continue to excrete bacilli for years and remain persistent foci of infection, but such cases are not carriers in the ordinary sense. For practical purposes the real source of infection is the active, sputum-positive case. Henry D. Chadwick, M.D. and Alton S. Pope, M.D. The Modern Attack on Tubercuolsis, The Commonwealth Fund, Revised, 1946.

# NEW APPLICATIONS OF LABORATORY METHODS IN DIAGNOSIS OF TUBERCULOSIS

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Since there is probably no entirely new laboratory method for the diagnosis of tuberculosis, the present discussion will concern itself with the special application of established laboratory procedures and with the description of methods not commonly used by the average clinical laboratory. It is most needful that the attention of medical men be directed towards methods of discovering tuberculosis in its "embryonic state" or before the disease has reached that critical moment of its evolution beyond which only death or at best a long convalescence can be predicted.

In spite of all that has been accomplished in antituberculosis work in this and a few other countries, tuberculosis is still one of the world's most devastating and universal scourges, capable of going wherever man and animals can go and taking one of the greatest death toll of any other disease. Even in this country it is still the leading cause of death of individuals from 15 to 30 years of age. I am not so optimistic as some who visualize a disappearance of the disease in twenty, forty or even a hundred years. There are countries in the world where people will probably be transmitting tuberculosis a thousand years hence, and improved transportation will make these countries our near neighbors.

In the more progressive countries, especially those not gravely disturbed by war and famine, the tuberculosis death rate has been declining over the last fifty years. In the United States the incidence of the infection has decreased from over 90 per cent to about 45 per cent of the total population in the last fifty years[1]. Of the 45 per cent who have been infected, 10-20 per cent carry living bacilli in their bodies; 1-2 per cent of them have "clinically significant" lesions; and about 0.1 per cent die each year.

In round numbers for the country these percentages represent about 60 million infected individuals, 6-12 million with living bacilli in their bodies; 600,000-1,200,000 with clinically significant disease; and 60,000 deaths occuring each year. The actual figure for 1943 was

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57,005 deaths[2]. There are also about 90,000 patients in hospital beds and about 200,000 more "at large" developing the disease and manifesting varying degrees of activity. In some, the disease is arrested as a result of early discovery and good treatment, the rest go on for the harvest by the Grim Reaper.

A more pleasant figure to contemplate is the 50 million infected persons whose infections have completely healed. Roughly, between 95-98 per cent of infections take place and heal without once showing any outward manifestation. Furthermore, most of these cases probably never expel tubercle bacilli; in fact, every clinical case of tuberculosis has negative periods in which no bacilli may be found. For example, after the infection has taken place there is a period of a few weeks or months before any bacilli appear in the secretions, even in cases that ultimately go on to a fatal termination. Toward the end of the disease evolution there comes a time, sought for in every instance, when even strongly positive cases become negative. Some cases become negative for a while and then turn positive months or years later, and some are alternately positive and negative over long intervals of time. It is clear that the finding of tubercle bacilli in all but frank clinical disease is difficult even under the best conditions.

What happens to tuberculous infections of the lungs also applies largely to extrapulmonary tuberculous infections. That is, the problem of finding tubercle bacilli, save for the frank open case, is one that requires skill, patience and the pursuance of special technical procedures, and even then the bacilli are not always found.

Just as negative findings do not prove the absence of tuberculosis, diagnosis of any given case is not always solved by the presence of acid-fast bacilli. First of all, there are many artifacts and saprophytes that simulate tubercle bacilli[3]. Not infrequently there are lung cancers (somewhere between 10 and 20 per cent of cases in our institution) having associate tubercle bacilli. Sometimes a few acid-fast bacilli may be found in a patient where the dominant pathology is bronchial asthma, emphysema or bronchiectasis. It can't be made too emphatic that there are a host of diseases that produce shadows in the chest besides tuberculosis. Occasionally other diseases may be concomitant with tuberculosis and play varying clinical roles. There may be one or more extra-pulmonary complications along with a pulmonary infection, and an enigmatic aspect of the extra-pulmonary foci is that they usually progress after the healing of the lung lesions (Marfan's law).

Finally, after typical acid-fast bacilli are found or even cultured, it is occasionally necessary to determine their virulence and type.

The microscopic examination of a section of surgical tissue or biopsy is sometimes a sure and relatively easy method of diagnosing tuberculosis. In the same category is the sternal puncture biopsy recently reported by Schleicher[4] to detect an early generalized miliary tuberculosis.

In the interpretation of the positive or negative bacillary findings, the tuberculin reaction is becoming a most valuable adjunct in the diagnosis of tuberculosis.

After all the facts have been found there are still unsolved problems relating to the clinical evaluation of the cases concerned or to the public health aspect of the disease.

For the present, however, only the most important methods of laboratory diagnosis will be described. These will include the collection, treatment, staining and examination of material for the presence of tubercle bacilli in pathological material; culturing; testing of pathogenicity, virulence, and type of tubercle bacilli; and the use of the tuberculin reaction.

A few less common methods of search for tubercle bacilli will be mentioned, as will a few important features of differential diagnosis of diseases that most commonly simulate tuberculosis.

*The Collection of Specimens.*—Specimens should be collected in sterile glass bottles with tight fitting corks. The size of the bottle is not especially important in the finding of tubercle bacilli so long as a representative sample of sputum is obtained. For single specimens we have used with satisfaction short, wide mouthed, 1 ounce bottle, stoppered with a No. 8 cork. For observing the total quantity and other gross characteristics, however, bottles must be of 4-8 ounce size.

We also have devised a safety metal container capable of accommodating 36 bottles in which the bottles fit into slots; the metal top fits tightly on the corks of the bottles and is fixed with lock

fasteners, thus preventing their "popping off" in transit. If the specimen is to be transported through the mails, a hermetically sealed jar or a screw capped bottle must be used and placed in a double container. Otherwise a sterilizing solution should be added to insure safety, in which case, however, the use of cultures or animal inoculations is precluded.

*Smears.*—Direct smears are made by selecting the most purulent or caseous particles with a platinum loop or tooth pick and spreading them as a thin "ground glass" smear over 3-4 square cm. of the 1 x 3 inch chemically clean slide. The smear is fixed over low heat and is then ready for staining. We use 20-slide trays with restraining pegs which prevent slides from falling off.

*Stain and Staining.*—The most elementary and yet most reliable method of demonstrating tubercle bacilli is the time honored acid-fast stain introduced by Ehrlich and perfected by Ziehl Neilsen and, more recently, by Cooper[5] and others. The minute details and technique need not be given here, as one of a vast number of variations is or should be known by all people engaged in medical work. The method generally used is the one recommended by the Committee on Approved Methods of the American Trudeau Society[6]. In our institution we use Cooper's modification of the Ziehl-Nielsen method.

The points to emphasize in making a stained smear by any method are to work with pure chemicals in preparing the stains and to stain the thinly fixed smear on a steam bath, or the low heat of an electric hot plate, taking care not to let the dye evaporate. If the dye begins to evaporate, it should be replaced from a dropping bottle. After 10-15 minutes the dye is thoroughly washed off with tap water. In our institution we use a fish tail burner, on the end of a water hose connected to a tap to wash off the trays of slides. The primary stain is decolorized with a solution of 5 per cent nitric acid in alcohol until the smear appears only as a faint pink film on the slide. After washing off the acid alcohol, tap water is applied again and the counterstain, a green or blue dye, is applied. Loeffler's methylene blue, because it is better known than others, is recommended, but not in its concentrated form. It should be diluted at least four times and perhaps better, ten times, because a deep blue dye conceals many acid-fast bacilli. To overcome the masking effect of the deep blue or green, Spengler[7] originally and lately Pottenger[8] recommended the use of aqueous solution of picric acid as a counter stain. The slides are washed again in tap water and dried on a warm plate but never blotted with blotting paper.

*Examining and Reporting of Findings.*—Examination is then carried out under a good oil immersion lens, preferably with binocular eye pieces, for at least five minutes, shifting fields with a fast and smooth working mechanical stage. The time can be increased to hours if the importance of the specimen warrants. An average 3-4 cm. smear should be completely covered in three to five hours. Rarely is it necessary to look longer than twenty to thirty minutes, for if no bacilli are found in that time, very rarely are any found after longer search.

The method of reporting the number of bacilli is not now given as much importance as in the days of the Gaffky scale, which today is used only by the older school of workers. It is more serviceable to report the method by which tubercle bacilli are found, with perhaps four semi-quantitative designations as, a few bacilli per slide; a bacillus per many fields; a few bacilli per field; many bacilli per field. It is more important to know whether the specimen was examined by direct smear or concentration, and whether it was a smear from a sedimented stomach washing, a culture, or animal inoculation.

While there is no constant finding on direct smear examinations because of the type of case studied, most of our studies performed when direct smears were used for diagnosis obtained positive results on about 65 per cent of all admissions. As the years have passed and more early cases have been admitted, this figure has gradually decreased. In some institutions where 60 per cent minimal infections are admitted the positive bacillary findings are all proportionally reduced.

*Fluorescent Microscopy.*—At this point mention should be made of the method of fluorescent microscopy, originally described by Hagemann[9] and Richards and associates[10]. The method consists of staining smears with a 1 per cent solution of auramine dye and examining in a dark room under a powerful ultraviolet light[11]. Due

to fluorescence of the dye which the bacilli have taken up, the bacilli appear as shining rods of light. A great advantage is that the high dry lens may be used and more fields may be covered than with the oil immersion lens. The staining is also much simpler. Although there are many sources of error, as yet uncontrolled, the method offers great promise for the future since it requires only about half the time of the standard method used at present.

*Concentrations.*—The concentration of sputum to facilitate the finding of tubercle bacilli was attempted early by Uhlenhuth[12], Ellerman and Erlandsen[13] and others. We have been using a modified Petroff method for nearly twenty years[14] that has stood the test of time. It consists of a preliminary incubation of the specimen for fifteen hours to bring about autolysis of the cells without destroying a proportionate number of tubercle bacilli; treating with an equal amount of 3 per cent NaOH, shaking in a mechanical shaker, neutralizing with HCl, centrifugating; then proceeding as in the preparation of a direct smear. An important advantage of the method is that if the total time of exposure to the NaOH is kept below thirty minutes, the sediment may be neutralized and cultured simultaneously with the direct examination. The above mentioned method has been found satisfactory for handling large numbers of specimens. There has been an average of over 200 specimens a day for nearly twenty years prepared by this method at our institution. Over the years many devices have been adapted to expediate and facilitate the work, but it would take too much space to describe every one in this report.

In several studies it has been determined that good concentrations will find about 15 per cent more positives than ordinary direct smear examinations.

*Culturing Tubercle Bacilli.*—The culture method has become one of the most dependable for finding tubercle bacilli in sputum, stomach washings, feces, pus, etc. Like most procedures newly adopted by a laboratory, culturing for tubercle bacilli is at first not always easy to carry out, yet with practice a good technician will be able to grow most of the viable bacilli in any given specimen. It might be stated as a guiding principle that the object of preliminary treatment is to reach a medium between the desired destruction of all contaminating microorganisms and the destruction of tubercle bacilli themselves. Tubercle bacilli are generally more resistant than most micororganisms in sputum but spore formers in urine and sputum offer much difficulty. A serious mistake is to assume that the tubercle bacillus is a "resistant red rod of wax that will endure any insult." True, some tubercle bacilli will survive much rough treatment, but it should be recognized that different strains vary greatly in their degree of resistance, and that some are "thin-skinned" and will be killed off almost as quickly as staphylococci. The object is to kill the secondary microorganisms but to allow enough tubercle bacilli to survive to obtain growth on the culture medium. If the exposure to the detergent is too prolonged, most or all tubercle bacilli will be killed along with the other microorganisms; if there is insufficient time of exposure to the detergent, the media will be overgrown with contaminations. Sometimes when the contaminations consist of only a few colonies, they may be scooped out, permitting the tubercle bacilli to grow, or the clear surface of the media may be scooped off and transplanted to fresh tubes or bottles of media. The inoculation of the material into guinea pigs will sometimes give results with badly contaminated specimens, although contaminants surviving treatment frequently cause death in the animals before the tuberculosis can develop.

The technique of culturing tubercle bacilli varies greatly with the type of material. The results are best with non-contaminated fluids (spinal, pleural, peritoneal), fresh sputum, or fresh pus. Urine, feces and badly contaminated material must be treated differently than other material.

Non-contaminated fluids should be inoculated directly without treatment. Fresh sputum should be mixed with a detergent, usually a weak acid, as 5 per cent oxalic acid or 3 per cent HCl, or an alkali as 3 per cent NaOH, allowed to stand for 30 minutes, centrifugated, neutralized, and inoculated by spreading thinly over the medium, which may be one of several recommended during the last decade. We have found it advantageous to use at one time several tubes each of two to four kinds of the best media. Slight differences in reaction, moisture, oxygen, tension, etc. sometimes will produce varying results in different media. The result does not always

seem to be due to the differences in constituents of the medium so much as to minor but important technical differences.

The best media devised to date for cultivating tubercle bacilli includes egg yolk in its composition. Dorset's[15] original medium has been modified by a host of workers, including Petroff[16], Loewenstein[17], Petragnani[18], Saenz[19], and many others, most of whom have been listed in a recent report by Stadnichenko, Sweany and Kloeck[20]. The reader is referred to this article for references on culturing tubercle bacilli. Milk, cream, potato flour and a dilute dye are also incorporated in most of the media. The recent method of Dubos[21] offers promise of a badly needed rapid method of growing tubercle bacilli. Whether it will grow them as do other media remains to be seen. It is the writer's opinion that the growing of tubercle bacilli will be both speeded up and simplified in the future, but until that time we must adhere to known dependable methods.

Good culture methods will find about 10 per cent more positive cases than examination of stained smears after concentration, and 25 per cent more than direct smears.

A few words of caution may be in order at this time regarding frequent causes of failure. The media should be prepared with utmost care with regard to the freshness of eggs, the cleaning and sterilization of the surface of the eggs, homogenization of the mixture, avoiding spore contamination, and finally low temperature inspissation of the tubed or bottle product. After seeding the material it is often necessary to leave access to some oxygen without permitting of a rapid drying of the media. A hermetically sealed tube will soon suffocate the bacilli. The cultures should also be grown in complete darkness, as any light will kill the bacilli.

*Stomach Lavage.*—For some obscure reason many patients who do not have sufficient quantities of sputum to expectorate, still pass tubercle bacilli over the epiglottis into the esophagus and thence into the stomach which acts as a catch basin for the bacilli. Probably several factors enter in; one prevalent in children and mental cases is the patient's inability to expectorate. There is also the probability that a certain watery type of secretion does not form a lump that can be raised by "hocking."

In one study reported earlier[22] we found bacilli by using some of the methods listed above in all but about 6.95 per cent of our patients, while eight years later the negatives rose to 14.21 per cent. As more early cases are admitted the number of negative cases will rise further and the search for bacilli will be increasingly more difficult.

The procedure for stomach lavage is to have the patient drink two glasses of water on a fast- from 100-200 cc. of the water, centrifuge, treat. outlined by Stadnichenko and Cohen[23], draw off ing stomach, pass a stomach tube in the manner incubate, neutralize and plant on culture media after the manner of working with sputum. Direct examination of the stomach washing is always done, but non-virulent acid-fast bacilli are occasionally found, therefore the culture or animal inoculation should always be done and only virulent bacilli considered as diagnostic.

Stomach lavage will add from 3-10 per cent more positives than can be obtained by other methods of sputum examination, depending upon the stage of development and amount of disease present.

It is well to note that stomach lavage positive cases with negative sputum do not produce a public health problem. It is only a warning that bacilli are coming from the lesions, but they are not getting out to infect other individuals.

*Tubercle Bacilli from Urine and Feces.*—Only a brief statement will be made concerning the methods of growing tubercle bacilli from urine and feces. The time of exposure to the detergent is usually extended from thirty to forty-five minutes and then the results are not always satisfactory because of the usual presence of spore-forming bacilli. It is advisable to inoculate a pair of guinea pigs with a specimen treated for only thirty minutes and take chances on the animals surviving the contaminations.

*Typing Tubercle Bacilli.*—When the type of bacillus is questionable, a simple typing method may be used as recommended by Sweany, Stadnichenko and Kloeck[20]. Important features are that mammalian tubercle bacilli will kill guinea pigs quickly while the avian type rarely kills them. Bovine bacilli kill rabbits within four weeks after .01 mg. dosage, while 1.0 mg. dosage of the human strain will produce only a chronic type of disease. Bovine bacilli grow poorly or not at all on glycerin media, while the other strains grow well on glycerin media.

Atypical and strains of low virulence are frequently found in skin lesions.

The suggestion of the use of pathological sections from surgical tissues or biopsies may seem unnecessary, but not infrequently skin, lymph nodes, surgically removed tissues, sternal marrow biopsies will result in diagnosis when all other methods fail.

*Culture of Blood for Tubercle Bacilli.*—The culture of blood for tubercle bacilli has been carried out by Loewenstein and associates[24] with reported success. The value of their data, however, is questionable and in his conclusions Loewenstein has allowed his enthusiasm to carry him away from his reason, especially when he implies that rheumatic fever, endocarditis and many other diseases are a form of atypical tuberculosis. The medium he uses is excellent, and he is probably one of the greatest exponents in culturing blood for tubercle bacilli, but the conclusions he draws are not justified. Since most of the blood findings of tubercle bacilli may be in cases never having clinical significance the problem seem to be chiefly of academic interest, hence the method will not be considered as a means of diagnosis of clinical tuberculosis.

*Supportive Methods of Diagnosis — Tuberculin.*—We shall now turn our attention to what might be called supplementary or supportive methods of diagnosis, and then discuss a few methods used in excluding a diagnosis of tuberculosis.

Of the former, the tuberculin test is of the greatest value. There was a time when tuberculin was looked upon as one of Koch's failures, but von Pirquet[25], Mantoux[26] and others saved it from oblivion by making use of its specificity as a diagnostic agent. At first its usefulness was confined to children under 6 years of age, but that time has long since passed. At present it has tremendous positive value in almost every one in the first half of life, since in the United States only a small percentage of people are now infected before adult life is reached. Furthermore, as the infection rate decreases its value will be progressively enhanced.

The principal positive diagnostic value of tuberculin in tuberculosis is that a positive reaction indicates only a former tuberculous infection. Outside of establishing the foregoing fact, tuberculin is useful in tracing infections to their source in family circles, in medical practice and for public health propaganda in school surveys.

There are other implications, however, depending on the circumstances and the quantity of tuberculin used. A strongly positive reaction in low dilutions, especially with clinical or x-ray signs in young people, is of much diagnostic value. For example, in patients under 25 years of age with characteristic infiltrative lesions in the upper third of the lungs, a strongly positive reaction in the weaker dilutions of tuberculin (O. T. 1-10,000, or the low dilution of P.P.D.) is strong supportive evidence of tuberculosis. If there are associated calcified lesions or clinical disease, the evidence is even stronger. Positive reaction in dilutions of 1-1000 or 1-100 have less value, but a study carried out on 600 tuberculous cases[27] where the sputum was negative upon the patient's admission to the sanitarium, revealed that most of such tuberculin-positive individuals either were clearly not tuberculous as shown by other methods of diagnosis or they were chronic cases in which tubercle bacilli were ultimately found. The decrease in sensitivity in the latter instance is probably due to desensitization after long intervals of exposure to tuberculo toxins.

Other causes of a decrease in positivity of tuberculin reactions are intercurrent diseases, healing of the infection, and overwhelming or terminal disease. Patients with a negative sputum without the above mentioned exceptions, who give a positive reaction only in 1-100 dilution, are rarely tuberculous. In 1-10 dilution they are extremely rare.

Negative tuberculin reactions have even more absolute value than positive reactions. In completely insensitive cases where there is not sufficient evidence to explain the decrease in sensitivity (as overwhelming disease) the patient is practically never tuberculous. For example, an insensitive young adult patient with ever so many "typical" lung lesions is practically never tuberculous. We frequently find people in the fourth, fifth and sixth decades entirely insensitive. A diagnosis of sarcoid is also facilitated greatly by a negative tuberculin reaction in the presence of other typical findings of the sarcoid syndrome.

By using the combined clinical, x-ray and laboratory data (including tuberculin) there are

few cases having chest ailments on which at least a presumptive diagnosis cannot be established. In the series of 600 cases referred to above, there were diagnostic errors in less than 2 per cent of the cases.

The study of sputum section, bronchial aspiration, tissue section for tumors, sarcoids and other pathology, complete bacteriological and mycological studies are some of the methods used to establish diagnosis in many obscure non-tuberculous cases. Since this paper calls only for a diagnosis of tuberculosis, none of these methods for diagnosis of non-tuberculous diseases is described.

SUMMARY

The important methods and problems in the laboratory diagnosis of tuberculosis have been reviewed. It is stressed that the finding of tubercle bacilli (the only pathognomic sign of the disease) is becoming increasingly difficult because earlier cases are being found. More refined and better applied methods are mandatory to keep abreast with epidemiological and public health requirements.

The best technic for concentrating, staining and culturing the tubercle bacillus has been outlined and methods for the collection and examination of sedimented stomach lavage are described, as well as typing and testing of virulence of strains of tubercle bacilli.

Because there are so many sputum-negative cases, supplementary methods are necessary to help establish a diagnosis. The most important of these accessory methods is a semi-quantitative tuberculin reaction which has extremely useful positive and negative values. There are also useful laboratory procedures in ruling out non-tuberculous conditions, most important of which are stained sections of sputum, fluids, aspirations and biopsies.

The search for a diagnosis of any given case should rest on a basic understanding of the disease, with clinical, x-ray and laboratory findings integrated in a manner that will usually permit of but one conclusion.

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# SURGICAL PRINCIPLES IN STRABISMUS

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Every surgical case of strabismus presents three large questions—

1. What muscle or muscles should be operated?
2. How much is to be done?
3. What technical procedure shall be employed?

The latter question receives much attention. Should a shortening operation be a resection, an advancement, an O'Connor Cinch, etc? The most plausible answer seems to be — use the procedure you know best. The tuck, the cinch, the resection each has its place. In recessions, the scleral fixation or some form of tenotomy is the operation most frequently performed. The tenotomy produces phenomenal results when indicated and carefully done. The extreme unpopularity of the tenotomy resulted from its abuse and improper performance. The tenotomy has a definite place in muscle surgery.

This type of procedure may be successfully employed in several conditions. One of these is the recession of a secondarily contracted muscle. All of the trauma associated with a recession may be avoided where a guarded tenotomy is sufficient to correct the deviation.

In any of these procedures it is vitally important to avoid trauma to the sclera underlying the muscle and the muscular sheath which contacts the sclera. Adhesions may be produced that will cause the muscle to act not from the point where it was attached to the sclera in a recession, or to the stump in a resection, but it will act from the point of adhesion. If this point is at the equator the muscle action will be correspondingly limited. In several cases where reoperation of a muscle was done, we have found the muscle firmly adherent to the sclera as far back as the equator. This undoubtedly indicates a definite error in surgical technic.

Another error that sometimes mars an otherwise successful operation is recession of the caruncle. This deformity is almost impossible to repair and results from too careless dissection of the conjunctiva and Tenon's capsule over the internal rectus.

While we are disscussing some of the errors in technique, there is one that is occasionally made but not often recognized. It is easy to see in this diagram how a tenotomy of the inferior oblique could unwittingly be accomplished while doing a simple external rectus resection. If the slightest doubt exists, it is well to pick up the inferior oblique before severing the lateral rectus at its insertion. This can be easily accomplished after the external rectus has been exposed.

The next question of how much to recess or resect is very cleverly answered by Doctor James White when he says: "Just enough". The amount of correction obtained for each millimeter of resection or recession will depend, in a large measure, upon whether the anamoly is one of innervation, structure, or insertion. Many times each of us has planned to recess or resect a certain number of millimeters, but when the muscle was lifted on the hook we have had reason to change our minds. It is well, however, to have some general rule by which to plan. In twenty-eight cases of resection of horizontal muscles, one millimeter of resection corrected an average of 1.9 prism diopters of deviation. The mean in this group of resections varied from zero in two cases to 6.2 prism diopters in one case. In thirty-four cases of recessions, one millimeter of recession corrected an average of 4 prism diopters. The mean was 6 prism diopters. It often occurs, then, that one millimeter of resection corrects 2 to 2½ prism diopters of deviation; recession of one millimeter corrects about 4 to 5 prism diopters. This is extremely variable and can be stated only as a generality. There are other general principles that can be laid down for most cases: the maximum recession of a medial rectus should not exceed 4 to 4.5 millimeters; a lateral rectus may be receded 5.5 to 6 millimeters. The maximum resection of a lateral rectus should be about 10 millimeters; of a medial rectus, 5 millimeters. Keep in mind that the equator is 13 millimeters from the limbus.

Usually not more than 25 prism diopters of squint should be corrected with any one muscle. If the angle of squint is greater than 25Δ, oper-

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ate two muscles; if greater than 50Δ, operate three.

We do not make too great an effort to fully correct the angle of squint in one operation. Where any appreciable vertical element is present, we intentionally undercorrect our lateral deviations at the first operation.

In muscle surgery the top priority question usually is: Which muscle or muscles shall I work upon? With this decision rests success or failure; not upon what suture is used or how it is placed in the muscle.

The *sine qua non* of good muscle surgery is accurate diagnosis. An accurate diagnosis can be made only after carefully evaluating the—

Refractive error;

the near point of convergence;

the angle of squint: distance and near in the cardinal fields;

the fixing eye;

Actions of the individual muscles.

Analysis of the fusion faculty.

Each of these must be carefully considered in arriving at an accurate diagnosis.

An approach in discussing surgery of stabismus can be made by dividing all squint cases into a few general types.

*Convergent Strabismus Without Verticle Component.* — The most frequent type of strabismus seen is the convergent type. Omitting the verticle factor, we have only two types of convergence; first, those cases in which fixation is alternated between the eyes; and, second, those in which the same eye is constantly used for fixation.

What type of surgery is most often successful in a convergent strabismus that fixes with either eye? In other words, what procedure should one do on a convergent squint which alternates fixation? Three procedures are possible:

1. Recession of the medial recti.
2. Resection of the lateral recti.
3. Combination of the two.

Recession of either one or both medial recti is indicated when the near point of convergence is excessive and the function of the lateral recti is good.

In a convergent strabismus in which a poor near point of convergence is found associated with definitely weak abduction motions, resection of one or both lateral recti is the procedure of choice.

In a monocular convergent squint, resection and recession of the lateral and medial recti of the squinting eye is usually performed when adequate to correct the deviation.

Divergent strabismus may be present in some cases only on distant fixation. In this divergence excess, recession of the lateral recti is indicated. Another type is that in which divergence is noted only on near fixation. The convergence insufficiency in this case must be corrected by resection of the medial recti.

Occasionally divergence excess and convergence insufficiency occur in combined form. The lateral and medial recti should be weakened or strengthened respectively in proportion to their involvement in the deviation.

In unilateral divergent squint, the same general principles apply that were discussed in unilateral convergent squint. Determine the paretic muscle; if the sound eye is fixing, strengthen this muscle and weaken its secondarily contracted direct antagonist. If the paretic eye is fixing, operate to correct the secondary deviation.

*The Vertical Component.* — The vertical element is often a factor in both convergent and divergent strabismus. Failure to recognize and correct the vertical deviation may result in overcorrection or undercorrection, immediate or delayed, in many post-operative squint cases. In reviewing a series of our squint records, not infrequently a case with a good result two months post-operatively, was not so good at a year or 18 months after surgery. In the greater percentage of these patients the vertical deviation, for numerous reasons, had not been corrected. Examination determines whether the vertical imbalance is a primary or secondary factor. Practically all vertical imbalances result from a paresis. These tend to become comitant, so it may occasionally be difficult to determine which muscle is paretic.

Dunnington proposed the following indications for surgery of the vertical muscles:

1. Disfiguring squint: rare.
2. Head tilt.
3. Diplopia.
4. Combined vertical and lateral deviation.

In this latter, it is usually advantageous to partially correct the lateral deviation first, unless the

verticle element is definitely predominant. When vertical anomalies are discussed, one of the highly debatable fields in strabismus is entered. We have attempted here to state briefly the indications and procedures which have given a successful result in the greater percentage of our cases.

The most frequent vertical muscle found to be paretic in our series, was the superior rectus. Not infrequently this condition is found bilaterally, producing a double hypertropia. In the surgical approach to superior rectus paresis, one of two things may be done: either strengthen the affected muscle, or recess the yoke muscle (or inferior oblique of the opposite eye). When shall we do the one: when, the other?

When a paretic superior rectus shows a genuine limitation in its field of motility, a resection may be indicated. This procedure is particularly sound when the paretic is the non-fixing eye. Not infrequently a secondary contracture of the inferior rectus will be present in this eye. It is the rule with a paretic superior rectus to maintain fixation with the paretic eye. Where this is not the case, pseudo-ptosis is sometimes present. This is easily detected when the fixing eye is covered causing the paretic eye to take up fixation. The ptosis immediately disappears and the interpalpebral fissure becomes normal. The ptosis, then, is due to the hypotropia and not to a paresis of the levator palpebrae. Complications sometimes follow resecion of a superior rectus; ptosis, if resection is too great: interference with action of the ipsilateral inferior rectus especially in downward gaze: fixation may be switched to paretic eye, bringing out a secondary deviation which may be greater than the original deviation. Do not resect superior rectus usually more than 6 millimeters. Resect only muscle, but dissect no more than necessary.

The paretic superior rectus may show little or no limitation in mobility. If it moves the fixing eye, which is frequently the case, recess the inferior oblique of the non-fixing eye.

In paresis of the inferior rectus, the same two avenues of approach are open. In most cases, we strengthen the inferior rectus rather than recess the contralateral superior oblique. But here, too, the indications for each procedure are ofttimes clearcut. If a genuine paresis of the inferior rectus exists, it may be resected or advanced. As with the paretic superior rectus, if the paretic muscle moved the non-fixing eye operation upon this muscle is the one of choice in most cases.

Few of us care to recess the superior oblique. However, in a rare instance this procedure may be indicated. One of the instances may be a paretic inferior rectus that fixes in its field of action. This produces a disfiguring secondary deviation of the sound eye.

Our same disfavor is incurred at the prospect of tucking a superior oblique in treating a marked paresis of this muscle. However, when a definite limitation in the field of motility exist, this may be the desired operation. A much more popular procedure in treating a superior oblique paresis, particularly when fixation is with the paretic eye, is weakening of the contralateral inferior rectus.

Another opportunity to avoid an operative procedure upon the paretic superior oblique may be a spasm of its direct antagonist, the inferior oblique. In this event, a weakening of the inferior oblique is employed. Cut at its scleral attachment, a much more complete paralysis will be produced than in a tenatomy at its origin.

In the rare cases of paretic inferior obliques, advance or shorten the paretic muscle if it is in the non-fixing eye or if its mobility is markedly disturbed. If the paretic eye fixes, recess the contralateral superior rectus.

The general principle in all of this surgery on paretic muscles is to strengthen the paretic muscle if in a non-fixing eye: if it is the fixing eye that is paretic and the field of mobility is not greatly disturbed, operate to correct the secondary deviation produced in the non-fixing, or sound, eye. It is hardly necessary to warn against excessively crippling both elevators or depressors in the same eye.

It is impossible to cover here such other subjects in squint as: strabismus fixus, retraction syndrome, and paralyses. However, modifications of these same principles apply. Rules and generalities are of value, but they do not relieve the responsibility of applying sound clinical judgement and the lessons of experience to each individual case of strabismus.

## SUMMARY

This discussion attempted to cover briefly the general principles of squint surgery. In sum-

mary these principles are:—

1. The first essential is correct diagnosis.

2. Operate the non-fixing eye where possible.

3. Divide the operation between the eyes in alternators.

4. Properly evaluate and correct the vertical deviations, especially in divergent strabismus.

DISCUSSION

Dr. Walter Stevenson, Quincy: It has been a great pleasure to listen to this presentation. The authors are to be congratulated for what in my opinion is a most comprehensive, remarkably condensed discussion of a subject that has received too little intelligent consideration. It is unfortunate what widespread misunderstanding exists regarding motor anomalies of the extraocular muscles and their correction.

It seems to me too bad that we could not have arranged a symposium on this subject in order to refresh our knowledge regarding the fundamental principles here involved. I want to agree with everything that has been stated in the paper. Many minor details or personal experiences could be related by me. They could not possibly be constructive and in no way would be critical.

To my mind the high spot in the paper was the emphasis laid on the importance of accurate diagnosis, or one as nearly accurate as the means at our disposal render such an ideal possible. Also, the dismissal of reference to specific methods of surgical intervention is worthy of serious consideration. An important point in the paper is the fact that vertical muscular deviation has a great bearing on the amount of lateral deviation, and that disregard of this is the cause of many more failures to achieve results than is the selection of the "John Jones" type of operation, rather than the method advocated by "John Smith."

The authors mentioned that retraction of the caruncle is due to the fact that the conjunctiva is dissected too wide and too far back when intervention is used for anomalies of the internal rectus muscle. It has been my experience, especially in recession of the internal recti muscles, that it is necessary to dissect pretty far back under the conjunctiva and caruncle, then with wound closing to bring the conjunctiva pretty far forward into the suture line, thus bringing the caruncle out where it shows no retraction whatsoever. Also, mention is made of inflicting as slight trauma as possible to the sclera and beneath the muscle surface which is being operated upon. This is very true; trauma should be carefully avoided, but what is also important is to see that there is a perfectly dry field before the wound is closed, thus avoiding blood clots beneath the muscle, which sooner or later organize and attach the muscle almost anywhere except than at the place desired with connective tissue. It has been my experience that a very careful and close coaptation of the conjunctival wound should be meticulously performed to avoid granulation tissue and makes for rapid healing.

I have nothing more than this to submit, except words of praise for a well-composed essay, and to congratulate these gentlemen for bringing this subject before us in such a comprehensive manner.

Dr. Richard C. Gamble, Chicago: This paper is full of sound surgical judgment. It follows, therefore, that any discussion of it is very agreeable both to the authors and to any discussor. The only exception is that the authors have the courage to champion tenotomy of a lateral muscle which, at the present time, is considered to be almost a surgical crime. I take the greatest pleasure in agreeing with them one hundred per cent. I have no objection whatsoever to recession of a lateral muscle except in children two or three years old, and I do not feel that they should have a strabismus operation anyway, at that age. Recession is a safe, effective operation and deserves the popularity it now has. Tenotomy is also a safe and effective procedure, provided the insertion only is exposed and the central portion cut, leaving just a little of the fibres at each side, with care taken to avoid cutting the lateral attachments or dissecting the conjunctiva off the anterior surface of the tendon. The tendon should not be exposed. This technic usually gives about 15 degrees of correction and I have never seen it cause paralytic divergence. On the other hand, I have seen a number of cases of paralytic divergence due to recession sutures cutting out, or from too many millimeters of recession being done.

It is possible, of course, to get overcorrection of the squint from either tenotomy or recession if too much is done. Many cases of late divergence are blamed on tenotomy, I think unjustly so. Most of such cases are monocular squints with amblyopia of the squinting eye. We have all seen such cases converge in childhood and diverge years later when no operation was done.

I also agree with the authors that it is wise to leave a case of convergent squint a little underdone. This is especially true of younger patients, and in those with monocular squint and amblyopia. Nature gives them some divergence later on. That is less true in older patients and in cases of alternating squint. It is not true of divergent squint.

The authors suggest recession of both internal rectus muscles in some cases in which the near point of convergence is excessive. I cannot quite agree with this, and would say that one should almost never recess both internal muscles. As the patients get older, these muscles become less spastic and convergence may be interfered with.

I read the paper dealing with vertical deviations with a great deal of interest and profit. My limited experience in this field does not permit me to discuss it.

Dr. W. W. Gailey, Bloomington: I trust I may be forgiven for extending my congratulations to Dr.

Morgan for his excellent presentation, inasmuch as I can assure you that the contents of this paper were fully and completely the result of his own efforts. I will admit that I read it several times and made some suggestions — the principal one being that he substitute a "which" for a "what." Other than that I was a simple bystander. Right now I am not quite sure that my "which" suggestion was correct. Anyway, I wish I'd written the paper.

The time allotted for a full discussion of the subject at hand is, I think, totally inadequate. However, there are a few points I would like to stress concerning muscle surgery:

1. The surgeon must make a complete survey of his case. In some instances a number of examinations are necessary.

2. He must have a plan of procedure firmly established in his mind before surgery is undertaken.

3. He should have a complete typewritten chart in his surgery, which will include (a) History, including vision with and without glasses; (b) cover test findings in the six cardinal fields; (c) a recording of previous operation or operations, if any; and (d) proposed surgery with qualifying remarks.

As to anesthesia, in our practice we use general anesthesia in all squint operations, with the exception of controlled tenotomies. We use pentothol sodium I. V. in all patients over 10 years of age. In addition to surface anesthesia in local cases you will find that retrobulbar injections of 4 per cent novocaine will give excellent results, but this will not anesthetize the inferior oblique. We make a dye dot at 3:00, 9:00, 12:00 and 6:00 o'clock, which makes orientation easy.

Muscle operations should entail a minimum of trauma. Delicate, careful dissections should be made. Handle the eye as gingerly as you would in cataract extraction. Particular care should be exercised in picking up the muscles, with no deep sweeping of the tendon hook. If the dissection is accurate the muscles may be picked up easily with a small tendon hook. We avoid the Prince forceps in recessions; and do not use forceps on muscles unless the portion of muscle within the grasp of the clamp is to be excised.

We have tried all manner of sutures, both silk and catgut. For fixing the muscle we favor 10 day chromic No. 4-0 with atraumatic needle; and plain catgut for closures. This closure suture may be interrupted or continuous. We have found with interrupted sutures we do not have granulomata. We have had no granulomata with continuous closures, but we have not used this type of closure long enough to be sure. Stitch cysts have occurred in about one out of one hundred cases. We find silk too difficult to remove in either adults or children. In tying sutures in recession, resection or advancements, one must make a surgical knot, tightened *just enough*. Strangulation of muscle tissue will occur if the sutures are pulled too tight, but if the suture is properly placed and properly tightened no trouble should ensue.

I have seen the Jamieson scleral bite include two or three millimeters of sclera, which is poor surgery. This much inclusion of sclera not only defeats one's purpose but may buckle the sclera. One to 1.5 mm. is sufficient to fix the muscle satisfactorily. It has been our policy to remove the eye dressings as early as possible as early motion is an essential. In my opinion, O'Connor's good results have been due in part at least to early removal of dressings, thereby permitting or encouraging early movement of the eyes.

If the surgeon understands which muscles are involved, and approximately to what extent; and if he estimates by study and experience how much shortening or recession is indicated, surgery designed to correct muscle anomalies becomes an interesting, fascinating and most satisfactory branch of ophthalmic surgery. However, the aim of the surgeon should be not only to obtain a good cosmetic result, but to strive above all else to obtain functional perfection, or as near to this goal as is possible.

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## CHILD PSYCHIATRY AND THE PRACTICE OF MEDICINE

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Child psychiatry is an integral part of the practice of general medicine. Although it is a specialty within the field of psychiatry, it can, perhaps, contribute more to the understanding of the psychological aspects of medicine than can any other section of psychiatry. The development of the character or personality of the individual can be seen clearly as one works with children. It might even be said that understanding the child is understanding the adult, for the adult variations of personality and character can be foretold in the child. The psychosomatic disorders of the adult are often one manifestation of childhood types of reaction patterns. This understanding and increased knowledge of the adult has come about as the result of clinical work and research with children.

At the Institute for Juvenile Research where we have been concerned with the genesis, diagnosis, and treatment of emotional and behavior problems of children we have become interested in the wider implications of these problems. One of these fields is the understanding and prevention of those psychological difficulties in children which result in somatic disturbances

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in the adult. We have, in addition, been interested in teaching the use of those psychotherapeutic techniques which can be handled by the average physician.

In order to illustrate our function, three cases will be very briefly presented. It is not the aim here to go into all the mechanisms and subtleties leading up to the parents' request for help. It is rather to show three typical problems which come to the attention of the average physician in the average community. These are all cases of troubled children and troubled parents. They might as readily go to their family physician as to come to the Institute. One of the children has a definite somatic problem. The second has a symptom which every general practitioner and pediatrician, at one time or another, has seen in his practice. The third child's history is presented to illustrate how fruitless and discouraging even the most intensive treatment may be. We acknowledge our limitations.

*Case 1.* Nick, a thirteen-year-old Italian boy is the younger of two children. He has one sibling, a sister 30 years old. Nick was referred to the Institute from the Neurological Clinic of the University of Illinois because of diffuse tic-like movements. In addition, he was being treated at the University Allergy Clinic for asthma and was on a limited non-allergic diet. As an infant he had exzema, which cleared up when he was about three years old.

The mother stated that for the past several years Nick had been developing "nervousness" and marked trembling, particularly when excited. He had, she said, a "terrible temper" and would turn red with rage. At such times he acted as if he wanted to hit back but "controlled himself" and swore instead of hitting.

On the psychometric examination Nick was found to be of dull intelligence.

It was the impression of the staff that the boy was forced to conform to very rigid standards, and that his rebellion took the form of tic-like movements and asthmatic attacks.

Because of a language handicap the mother could not be treated, but Nick was seen by a psychiatrist once a week for six months. During this period the asthmatic attacks ceased and he was able to return to a full diet without recurrence of the attacks. His tics almost completely disappeared, his relationships improved, his outlook became more mature, and he was able to express his feelings more easily, The therapist emphasized that good progress had been made, but that further treatment was indicated.

*Case 2.* Donald, aged 6½ years, was referred at the suggestion of several private physicians. Donald is the older of two boys, his brother being ten months old. His problem was that he screamed at night, awakening the family. There were no known night terrors or evidence of disturbing dreams. The screaming had started about two years earlier and had persisted ever since. The mother said she had taken Donald to a number of physicians who had prescribed what she called "sedatives," and that Donald would be better only while he was taking the medicine. Finally the physicians mentioned earlier suggested a more intensive study.

Donald had not been doing well in school and had been tutored at home.

The mother told us the following incident which be believed to be significant. Donald was breast-fed, but their physician didn't approve of the 2 A.M. feeding. For three months Donald cried at night. The parents often felt so badly they would cry, too. On several occasions they called their family physician, but he was adamant and convinced that the baby should not be nursed at 2 A.M. Finally the parents changed physcians. The second doctor recommended the 2 o'clock feeding and with that the crying ceased. Development then went on normally until the present difficulty arose.

Donald was found to be of average intelligence. When the psychiatrist saw him he was impressed by the absence in the child of any neurotic features. The mother, however, appeared to be a rigid, somewhat demanding woman. Since she seemed to harbor some guilt about Donald's early difficulty, she was encouraged by the psychiatrist to discuss her feelings. It was evident that she was limiting and restrictive with Donald and needed help in handling both the children, and particularly in understanding and realigning her attitudes. Although she said she wanted help, when it was later offered, she refused.

About three months later the psychiatrist called the mother for a follow-up check. She said the night screaming had entirely cleared up and that Donald was also doing much better in school. She was very much pleased with the results. It was evident that the reassurance and support the mother was given had helped her considerably.

The symptom, screaming at night, appeared to have been a regression to an infantile type of behavior. The psychological basis for the symptoms developing at a particular period may have been related in the first instance to Donald's starting school, and in a second, to his mother's second pregnancy.

*Case 3.* David, a nine-and-a-half-year old adopted boy without any siblings in the new home, was referred to the Institute by the adoptive mother in 1941.

He had been adopted in 1939 when he was seven and a half years old. Shortly after his arrival in the home he evidenced considerable aggression. He was headstrong, afraid of adults, but still deliberately disobedient and defiant. He was excitable, lost control easily and smashed things. He bit his nails and slept badly. The school reported that he was doing very

poorly, although psychometric examinations showed him to be of superior intelligence.

David's real mother is the adoptive mother's sister, who had been twice married and divorced, so David had been subjected to a great deal of emotional deprivation and to very insecure relationships. When the adoptive parents decided they wanted a child, they felt it their duty to "begin at home," so David was adopted.

The staff felt that both David and his adoptive mother were in great need of help, so arrangements were made for the mother to be seen by a female psychiatrist and the boy by a male social worker. The mother came in weekly for psychiatric treatment over a period of nine months, and David was seen fairly regularly at weekly intervals for almost three years except for the usual summer vacation and other normal interruptions. Therapy for both was discontinued when the therapists left the Institute.

Despite this intensive treatment, however, David's aggressive behavior continued. Recently he was referred again because he had been picked up on three burglary charges. The examination at this time indicated that his antisocial patterns were becoming set. He was sent to St. Charles where the psychiatrist there stated that David was as typical a psychopath as he had ever seen.

These problems are typical of those we see in our clinic. By studying them we can much more easily understand the adult's difficulties. Nick can, as a man, be treated more adequately if his physician appreciates the relation between Nick's asthma and his passive, dependent, hostile feelings.

When Donald, as an adult, wants help for periods of nocturnal dyspnea or asthma, we can formulate a better therapeutic plan with our knowledge of this emotional background. We can also aid the patient to face the real etiological factors in his difficulty. More important, we can probably avoid the use of countless drugs, devices, and other therapeutic techniques which are merely crutches for both patient and physician.

The doctor will undoubtedly be asked for his opinion of David, the adult. The physician everywhere is also the psychiatrist and counsellor. Some understanding of David's background will help the doctor make a proper decision for the welfare of both David and the community.

The average doctor argues, "How can I treat emotional problems? I have so little time. I don't know how. They are beyond me."

How many times have we heard extremely competent clinicians anticlimax their therapeutic plans with "and the patient must also be treated with psychotherapy," or, "This condition is amenable to psychotherapy," but seldom do we read of psychotherapeutic techniques. The conscientious doctor, anxious to help his patient, but unaware of any methods, throws up his hands. Sometimes he even gets mad at his patient for bringing him such an insoluble problem.

Actually, every doctor practices psychotherapy. Unfortunately, the doctor-patient relationship has never been sufficiently understood or used to its fullest extent. The average physician is not aware of the powerful positive feelings which his patients have for him. The recently delivered mother idolizes her doctor. The man recovered from surgery for an acute appendicitis believes his surgeon is all-powerful. The frightened child who has had kind, unhurried attention and prompt relief from some painful condition will discuss with his doctor subjects which even the most skilled child psychiatrist requires hours of careful work to uncover.

The doctor has, therefore, a basic requirement for successful psychotherapy, namely, the confidence of the patient, and from this point he can easily develop other techniques. If he listens with interest and understanding, but at the same time objectively, he can accomplish much in therapy. The mere unburdening has eased many a patient with a psychosomatic problem. Often the physician's support in the form of encouragement, appreciation of the patient's attempts to help himself, and the simple acceptance of the patient's complaints may be enough. Advice should be sparingly given. When suggestions are made, the doctor must be reasonably certain of his ground.

Sometimes it is wise to see a patient three or four times for fifteen or twenty minutes before cautious plans can be formulated. Sometimes weekly sessions over a long period of time may be necessary. Psychotherapy does take time, but it isn't any more time-consuming than is the treatment of tuberculosis, cancer, orthopedic disorders, and many other chronic conditions. The patient may be just as ill with a neurotic difficulty but he can usually remain on his job. We can't say that of the tubercular or cancer patient.

The skill of psychotherapy comes from practice. The fundamental tools are either there

or easily available. The results in terms of satisfied patients are well worth while.

Dr. S. Schroeder, Chicago: These cases illustrate what can happen if the general practitioner recognizes emotional factors. I might also emphasize the advantage which the family physician would have in many communities. In many communities the family physician would not need to get the family history. He knows the emotional and social factors and things which he does not get from his own observation he gets from the grapevine through his wife or children. The way this can be handled is illustrated by the following case. In a town of 20,000 in Illinois a doctor has been practising for over twenty-five years. He was called to see a little girl of seven who had what the family said was paralysis; whenever she started to walk across the room her legs would give way and she would have to take hold of a table or chair or fall to the floor. He was very much concerned and he investigated many things. He felt he really needed neurologic help and was trying to decide to which clinic he would send the child for study and was trying to persuade the parents that she would need some study by specialists. As he was thinking these things over he thought of some factors in this family. The mother told him that she could not leave just then because she had company. As he went over the history he realized that this girl was the youngest of five children, considerably younger than the fourth child and had always been spoiled by the parents and the older brothers and sisters. Just previous to the onset of her illness one of the older sisters had come to visit with her two small children who were just younger than this little girl. The grandparents had made a great deal of fuss over the grandchildren and had showed them off. The doctor began to wonder if this might not be a factor. After all, there are all sorts of ways of meeting competition. He talked to the little girl; she liked her little niece and nephew; he could not get very much from her. He talked to the parents. Then he told them several things they might try in order to work with this girl and minimize rivalry with these younger children. As we might expect, when these recommendations were carried out, her symptoms cleared up without any neurological attention and without anything more than some simple psychology done by the general practitioner. You see the advantage he had. If that youngster had gotten a lot of attention from being studied at some clinic it would have been very gratifying. Evenutally she might have come to us and we would have gotten a social history and finally worked out the emotional side. The family physician if he is alert can do all this.

Aside from the fact that the family physician can make a diagnosis if it is not too deep a problem and can do some therapy, he always has some responsibility as to therapy. He may need to get some help from people who are more experienced. We realize that the way in which this case was handled may well be the determining factor in future adjustment. Here this girl can be taught how to meet the competition she is between a well adjusted adult and one that is neurotic. sure to meet in adult life. It will make a difference

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## ANEMIA IN PREGNANCY — CLINICAL MANAGEMENT

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Recent advances in hematology have led to a better understanding of blood disorders. The development of hematological specialists, uniform standardization of cellular morphology, the recognition of the neccssity of a complete peripheral blood study with an exacting technique and, the use of bone marrow studies obtained via the simple sternal puncture method have all brought about this achievement. Likewise a simple and direct classification of blood diseases has clarified therapy.

Ever since observers noted a change in the normal blood picture during pregnancy, the interpretation of these findings has been intriguing to both the obstetrician and the hematologist. Recent reports have done much to clarify the understanding of these normal findings. Similarly attention has been called to the use of the newer complete blood studies in giving aid toward both the hematological and the obstetrical management of all blood disorders associated with pregnancy.

It is the purpose of this article to review the findings noted in these anemic states and to suggest therapy for these conditions.

*Blood Examinations During Pregnancy.*— Every pregnant woman should have the following blood study made on the first prenatal visit: hemoglobin (Sahli, Newcomber, or Photo-electric method), erythrocyte and leucocyte counts, and differential smear. In the latter, one should study the character of the erythrocytes and leucocytes, and note the number of blood platelets. A Kahn or Wasserman test is imperative at this time. The blood type and Rh factor may also easily be dctermined at this occasion.

Thc normal findings to expect during the three trimesters of pregnancy are shown in the following table.

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From the Department of Obstetrics and Gynecology University of Illinois College of Medicine.

| | *3rd Trimester* | *7th Day Postpartum* | *2nd Trimester* | *1st Trimester* |
|---|---|---|---|---|
| Hemoglobin (grams) | 12.5 | 10.0 | 10.0 | 12.0 |
| Erythrocytes | 4,250,000 | 3,500,000 | 3,500,000 | 4,000,000 |
| Differential Smears | Normal | Normal | Normal | Normal |

The lowered values of hemoglobin content and erythrocyte count are due to blood dilution alone, and are merely indicative of the hydremia of pregnancy (this thesis of Dieckmann has been confirmed by the author's study of the peripheral blood and bone marrow during pregnancy). The hemoglobin should be repeated at the 7th month and again close to term. With normal findings no treatment (so called prophylactic treatment) is needed.

If the findings obtained are below those of the normal values to be expected during pregnancy or if the clinical history and examination reveals anything suspicious of a blood disorder, a more thorough examination is imperative.

The above studies are to be repeated. The hematocrit reading, icterus index, and sedimentation time should be recorded. One can then compute the mean corpuscular volume (M.C.V.), mean corpuscular hemoglobin (M.C.H.) and the mean corpuscular hemoglobin concentration (M.C.H.C.). This will enable one to determine the character of the cell and its hemoglobin saturation.

Should these findings reveal a definite anemia or blood disorder, a bone marrow analysis is then in order. The bone marrow is readily obtained by use of the simple sternal puncture method. The correlation of the peripheral blood and the bone marrow findings will enable one to diagnose the blood disorder accurately, and will point to the plan of treatment.

## ANEMIA

Anemia means a lowering in the hemoglobin value and/or the erythrocyte count below those noted during normal pregnancy. This is merely a symptom and the anemia may be due to abnormal blood formation, the loss of blood, or increased destruction of blood.

*Iron Defiiciency Anemia* is the most common type of blood disorder encountered during pregnancy. Since this often preceeds the pregnancy, the anemia is usually noted at the first prenatal visit. However, as the anemia may develop during pregnancy a routine check-up at the 7th month or near term will reveal this insidious state. When noted, the diagnosis should be confirmed by a thorough examination of the peripheral blood. This will usually rule out other blood diseases. One should always search for a source of chronic blood loss as a causative factor (Polyps, hemorrhoids, fissures, renal infections, etc.). Treatment consists in (1) removing the cause, (2) adequate iron therapy (ferrous sulphate grains 15 daily), and (3) insuring an adequate high caloric high protein diet. If improvement does not occur within four weeks, bone marrow analysis should be made. Bone marrow studies should always precede therapy in any severe anemia regardless of the clarity of the peripheral blood picture. If first discovered when the patient is near term, one or two blood transfusions will do much toward insuring a normal blood picture during and after labor.

The blood picture must be checked during the puerperium in all patients who have had excessive blood loss during or following delivery, sepsis, or received chemotherapy. Blood transfusion raising the blood to its proper level followed by adequate iron and dietary therapy will rapidly correct the anemia.

*Pernicious Anemia of Pregnancy* (megaloblastic anemia) is to be suspected in (1) any anemia developing during pregnancy without cause, (2) a severe anemic state, and (3) in an anemia that fails to respond to iron therapy. The diagnosis is readily made by the finding of megaloblasts in the bone marrow. The peripheral blood picture is often confusing and may simulate other anemic states. Thus bone marrow studies are essential to proper diagnosis in suspected cases. The typical peripheral blood picture is that of severe anemia with a large erythrocyte (maccocyte) well filled with hemoglobin. The finding of extremely large poly-

morphonuclear leucocytes is another aid in diagnosis.

The ultimate prognosis here is excellent as complete recovery follows delivery. The children will be healthy. The problem then is to keep the anemia under control during the pregnancy. This can be done by the use of repeated blood transfusions and adequate oral and parenteral liver therapy. The blood must be checked at weekly intervals and blood transfusions should be repeated as often as is necessary. Iron need be administered only if the hemoglobin concentration is low.

*Rare Blood Disorders.*—Other blood conditions are but rarely associated with pregnancy. Hemolytic anemias, leukemia, purpura, Hodgkins, and Banti's syndrome have been studied and reported even though the number of cases observed has been exceedingly small.

cross matching of blood by properly qualified and skilled technicians is an essential. The Rh factor is to be determined in both donor and recipient. Needless to say the donors must be healthy and have negative Kahn tests. Transfusion equipment must be asceptic and pyrogen free. The blood had best be given slowly and an attendant should be present during the entire procedure. Constant vigilance toward the minutest details will prevent dangerous complications.

When blood is used the amount given should be determined by the effect on the blood count rather than a preconceived dosage such as 500 or 600 cc. One is to be exceedingly liberal in the amount of the transfusion.

SUMMARY

The average blood finding and the treatment

| | Normal Pregnancy Physiological Anemia | Iron Deficiency Anemia | Pernicious Anemia of Pregnancy |
|---|---|---|---|
| Hemoglobin (Grams) | 10.0 | 7.0 | 6.0 |
| Erythrocytes | 3,500,000 | 2,750,000 | 1,950,000 |
| Differential | | Microcytes | Macrocytes |
| Smears | Normal | Hypochromic | May simulate iron deficiency anemia. |
| Bone Marrow | Normal | Normoblastic | Megaloblastic |
| Treatment | None | Ferrous sulphate (gr. xv. daily) Remove causative factor. | Blood transfusion (Repeated) Liver (adequate) |

One must remember that a lowering of hemoglobin or erythrocyte count values (i.e. an anemia) may be only part of a primary blood disorder. This is merely a reminder that a thorough study of the peripheral blood must be made whenever an anemia is noted. Similarly bone marrow studies are necessary in all cases of unexplainable anemia or one that does not respond to simple therapy. Then the true primary blood dyscrasia will readily be diagnosed.

*Blood Transfusion.*—The rapid restoration of the erythrocyte count and the hemoglobin value to its normal level during and following pregnancy can be easily and swiftly accomplished by the liberal use of transfusion with either whole blood or concentrated erythrocyte solution.

However, one must be exceedingly careful to prevent transfusion reactions. Proper typing and

of the anemias of pregnancy may be summarized as shown in the table.

CONCLUSIONS

1. Routine hemoglobin, erythrocyte and leucocyte counts, differential smear, Kahn or Wassermann test, blood type, and Rh factor determinations are necessary on all pregnant women at the first prenatal visit. The hemoglobin should be rechecked at the 7th month and close to term.

2. The physiological anemia of pregnancy is not an anemia and must be considered as a normal blood finding during pregnancy.

3. Complete analysis of both the peripheral blood and sternal marrow is essential in the presence of a true anemia or a suspected blood disorder.

4. The management of the anemias commonly seen during pregnancy has been described.

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# MINIMAL PULMONARY SHADOWS AND THEIR MANAGEMENT

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GLEN ELLYN

Today more x-ray films of the chest are being taken than ever before in the history of medicine. X-ray surveys of whole populations are being done. The tempo of mass surveys has been greatly stimulated by the experience of the Selective Service system. The group they surveyed was in the prime years of life when health should be at its best and yet pathology was found. The tuberculosis morbidity of the Army in World War II when compared to World War I shows a tremendous improvement due mainly to the weeding out of the unknown cases of tuberculosis. In civilian groups such as among patients entering general hospitals, the evidence of significant chest pathology has been found to be as high as 1% to 4%. Hodges, University of Michigan, states that "Photofluorography employed to survey the chests of all patients regularly registered in hospitals and clinics can be expected to disclose signs of significant thoracic disease in 8 to 10% of the patient group."[1] We can no longer depend on the stethoscope to determine the state of a patient's lungs. The x-ray of the chest should be a part of every complete physical examination. The general practitioner of medicine armed with newer methods of diagnosis and aware of the limitations of earlier diagnostic procedures can recognize tuberculosis in its early stages if he has a lurking suspicion it may be present."[2] Years ago a simple urinalysis often was the only laboratory procedure in addition to the physical examination of the patient that was done. Today a complete urinalysis, a complete blood count and a Wasserman test are considered routine for a basic physical examination. To this we should add an x-ray of the chest. Wilson states, "routine blood cell counts reveal dyscrasia in a small fraction of 1% of cases, routine urinalysis reveals diabetes in about 0.4% and routine serologic tests reveal syphilis in about 2%. These routine laboratory procedures have been required for years in every good hospital and clinic. Yet today these same institutions are neglecting a procedure that will uncover 8 to 10% of significant thoracic disease."[3] Often the Roentgen findings of the heart and lungs are normal, however, not infrequently the physician may be surprised by pathology revealed in the Roentgen film which if this had not been taken would later have led to the patient's harm and the physician's embarrassment.

In these films taken of healthy groups, shadows are often found that represent, from a radiological viewpoint, an early tuberculous infiltration. When such a finding is discovered in an apparently healthy asymptomatic person, what should the physician do? What advice should he give the patient? What procedure should he follow?

It is known that today the relatively benign primary invasion of tuberculosis may be delayed until adult years. It is also true that it is sometimes impossible to differentiate between the primary phase and the reinfection phase of tuberculosis. If the date of contact and the date of the beginning of allergy to the tuberculin test can be determined, the subsequent pulmonary shadows can be followed and the diagnosis of the primary invasion made with certainty. When a physician is confronted with a film that shows hilar calcifications in a patient with a positive tuberculin reaction, and also a subclavicular shadow, he must conclude that here is a suggestion of the classical beginning of reinfection tuberculosis. Are all such shadows tuberculous? Are all such shadows an indication for sanatorium care? It is difficult to convince some of these patients that they should go to bed. If we put all such individuals to bed we may be doing them an injustice, from an economic, social and psychological viewpoint. However if this Roentgen shadow is progressive tuberculosis, it should be promptly treated and definite instructions should be given the patient for a strict regime with no compromises.

Read before Joint Session of Illinois State Medical Society at Chicago, May 14, 1946.

One of the outstanding characteristics of tuberculosis is its tendency to heal. Pathologically reparative processes are in evidence even in the presence of progressive disease. Roentgen film evidence of this is often found in an individual who was not aware that he had been infected, but the film of his chest shows healed tuberculosis. Such cases as these may become open cases and should be periodically checked and advised. The physician's duty when confronted with the parenchymal infiltration is to determine the stability of the process. From the radiological viewpoint a soft appearing shadow with irregular margin, with or without cavity formation, represents active tuberculosis. The shadow with well defined margins and a more homogenous opacity may be a progressive or a regressive infiltration and needs careful and prolonged study. Mayer and Rappaport[4-5-6-7] have suggested the concept that some of the shadows are prephthisical tuberculosis. That term "prephthisical" applies to all lesions in the chest that precede the development of chronic tuberculosis, to all stable lesions and to pulmonary shadows that follow a recent developing allergy to the tuberculin test, also to all cases where there is a recent pleurisy with effusion.

As an orderly course in such a study the following procedures should be employed. X-ray films of different penetration may be necessary. Some insist on stereoscopic films. It is assumed that the films are made with modern equipment with at least 100 M.A. of power and at a six foot distance. The tuberculin test should be given. Either old tuberculin or P. P. D. can be used. One test may not be sufficient. It may be necessary to give several tests increasing the dose if the first ones are negative. Krause says[8] "Tuberculin testing is the only procedure which unassisted, can settle the diagnosis of tuberculosis. But it can do this only in a negative way. If then, a subject for diagnosis, who exhibits no interferring factors, fails to react to tuberculin he is to be regarded as non-tuberculous". The sedimentation rate may or may not be accelerated. If it is rapid it is suggestive of tuberculous activity. An accurate temperature record should be kept for at least a ten day period. Taking the temperature at 10 A.M., 4 P.M., and 8 P.M. will usually suffice. The patient should be instructed in the use of a thermometer. If this is impossible a responsible person should keep the record. Thermometers should not be left in for one minute, but for a minimum of five minutes or longer. The technique of keeping the thermometer under the tongue with the lips closed is a small detail but important and should be emphasized. The patient should be required to time his temperature taking by the clock and not by his idea of five minutes.

The examination of the sputum is of great value if the patient expectorates. Routine smears are not reliable. Three consecutive 72 hour specimens should be examined by the concentration method. If these are negative, cultures should be made. If these are negative three consecutive gastric washings should be done and the washings examined by the concentration method. Guinea pigs should be inoculated and cultures made in order to identify as tuberculous, any acid fast organisms found in the concentrated specimens. Blood studies in most of these cases can help but little. They may be very valuable in the differential diagnosis of other conditions. There is a relative leucocytosis in moderately advanced active tuberculosis and later a monocytosis with a decrease in lymphocytes in progressive disease. A relative lymphocytosis occurs in the quiescent stages of the disease. The hematological changes that occur in these early infiltrations are too slight and too variable to be of prognostic significance. A soft appearing infiltration with rapid sedimentation rate with or without a low grade temperature variation is definite indication for further sanatorium observation. A patient whose temperature and sedimentation variation is normal and whose x-ray shadow looks hard and well defined can be kept on extended observation without interruption of his normal program unless gastric specimens should prove positive. Such cases should be observed at least every thirty days with an x-ray of the chest, a sedimentation determination and a ten day temperature chart. If after three successive monthly examinations there is no change noted, the observation period can be lengthened to every sixty to ninety days for at least a year. If the patient does not cough and the Roentgen shadow does not show absorption a gastric washing should be done every three months with the examination of a concentrated specimen and a guinea pig inoculation at least

for the first year of observation. Length of later observation periods would depend on the regressive character of the shadow. It should be kept in mind that a recceding shadow is not necessarily healed tuberculosis. Even if the shadow should entirely disappear the patient should be periodically re-rayed to watch the area in question as active parenchymal disease may later blossom again.

This paper is in no sense a complete discussion of this subject. It does not cover the differential diagnosis of parenchymal shadows. It is assumed that differential diagnosis has already been done and that other possibilities have been excluded. It is concerned only with what might be incorrectly called typical tuberculous pulmonary infiltrations. It is written to emphasize the need for the accurate determination of the significance of such shadows. Such shadows should not be dismissed lightly. Shuch cases should be held under strict observation for an indefinite period.

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## THE EFFECT OF VARIOUS TYPES OF THERAPY IN THE MANAGEMENT OF THE IRRITABLE BOWEL SYNDROME

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CHICAGO

Purgatives and rectal irrigations were among the first forms of medical therapy according to most historians. The list of drugs used for the purpose of regulating bowel habits has increased wih the passage of years, but there still remains much empiricism in the choice of medications for this purpose. Among the numerous reports in the medical literature discussing various phases of bowel management are those of Morgan[2], Portis[1], and Rehfuss[3], but in few of these are comparative clinical studies available. These authors concur in the frequent need for laxatives, such demulcent substances as agar, liquid petrolatum, psyllium seeds and agar with liquid petrolatum, but do not commonly employ drastic purges.

The present study was undertaken to compare the effects of a hydrophilic mucilloid, a hydrophilic gum, emollients, saline cathartics and dietary measures in regulating the bowel habits of a controlled group of ambulatory patients with an irritable bowel syndrome. The investigation was begun with forty-four subjects, fifteen of whom ultimately become delinquent in attendance. Of the twenty-nine remaining subjects, all had complete medical studies which excluded any active disease processes involving either the gastrointestinal tract or other systems. Roentgenographic studies of the twenty-nine patients showed normal gastrointestinal tracts in twenty-five, two presented roentgen evidence of healed duodenal ulcers, one had diverticulosis and one had a duodenal diverticulum. Constipation and abdominal distress were presenting complaints of all patients.

PROCEDURE

The patients were supplied with printed diaries on which to record their food intake and bowel habits. They were interviewed at weekly or bi-weekly intervals by one of us. A control period of one to four weeks, during which the patients were on a bland diet, preceded the investigation of the effects of any of the medications.

In five subjects controlled diet alone alleviated their complaints. During the control period an antispasmodic (tincture of belladonna and elixir of phenobarbital and/or Pavatrine with Phenobarbital) was prescribed if it was considered necessary. The twenty-four patients not responding to dietary management were then placed on one of the medications under study for four weeks, (liquid petrolatum, Petrogalar, saline [sodium phosphate], Bassoran or Metamucil) in conjunction with the controlled diet and antispasmodics. For at least one week between the test periods control observations were again made during which dietary control and antispasmodics only were employed.

The bland diet prescribed included at least three servings of cooked and mashed or pureed

From the Department of Medicine, St. Luke's Hospital, Chicago.

CHART 1

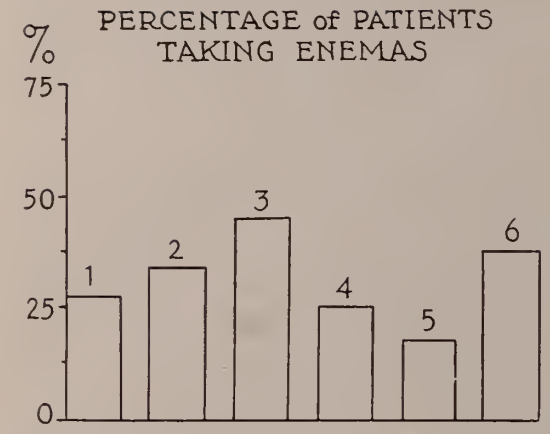
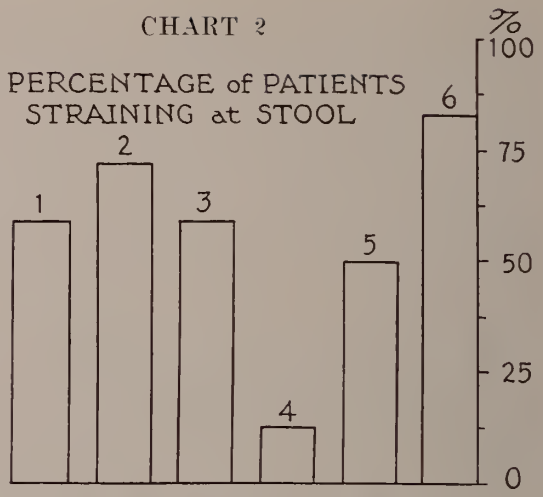



CHART 2




1-Hydrophilic gum 3-Liquid petrolatum 5-Sodium phosphate
2-Petrolatum-agar emulsion 4-Psyllium mucilloid 6-Control period

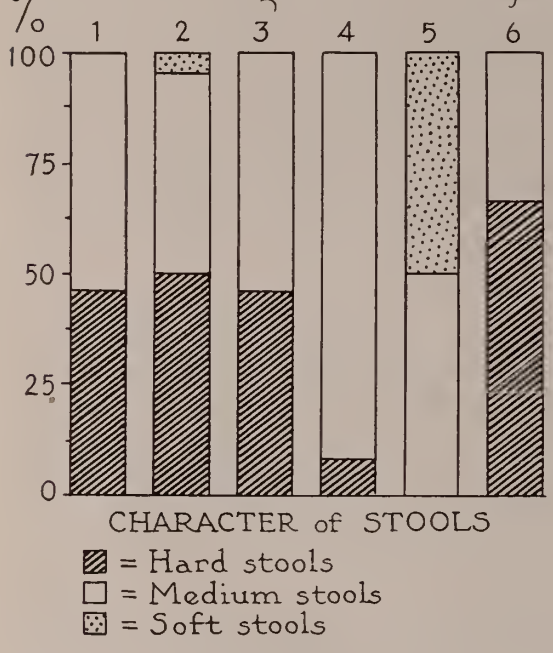



CHART 3

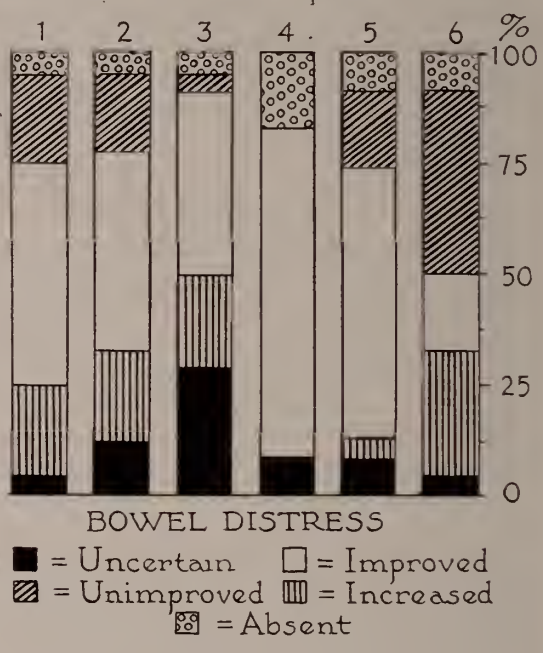



CHART 4

vegetables or fruit, in addition to optimal amounts of all protective food elements. This diet was low in foods irritating to the intestinal tract or those which are generally believed to produce flatulence or are digested slowly. The patients were also instructed as to their water intake; that is, their required fluid intake was determined by the medication being taken at the time. A gum or mucilliod product demanded a greater fluid intake than a liquid petrolatum or a saline preparation. The data resulting from these observations are graphically illustrated in Charts 1 to 4.

DISCUSSION

Therapeutic efforts toward the relief of constipation in patients wih an irritable bowel syndrome must be continued over prolonged periods of time. Cathartics which exert their action by direct irritation of the intestinal mucosa have no place in long-term bowel management. The data obtained from our group of patients indicate that the daily administration of a saline cathartic regularly produced loose, unformed stools (Chart 3) but that the associated increased bowel irritability resulted eventually in more,

rather than less, abdominal discomfort for the patient (Chart 4).

Liquid petrolatum produced rather erratic results (Charts 3 and 4) quite in accord with most clinical experiences reported. When administering liquid petrolatum over prolonged periods of time, the alteration in the absorption of the fat-soluble vitamins in subjects receiving daily doses of liquid petrolatum must be taken into account. The continued ingestion of liquid petrolatum by animals resulted in an impaired assimilation of vitamin A and a retardation of growth[4,5]. The studies of Tworts[6] and of Hirsch[7] have indicated that infiltrative pathlogic changes of various organs, particularly the liver, followed the cutaneous application or ingestion of liquid petrolatum and other similar hydrocarbons.

Gray and Tainter[8] reporting on the use of hydrophilic colloids in the treatment of constipation stated that acacia, karaya, tragacanth, bassora, agar, Irish moss and psyllium seed all act by virtue of their respective ability to retain water and thus produce a viscous colloidal suspension. Preparations containing these hydrophilic colloids produce a stool of a medium soft consistency, increase the bulk of the stool and have a lubricant action on the intestinal mucosa, all of which facilitate peristaltic activity as a result of the distention of the intestinal wall. In this connection our data indicate that both the psyllium mucilloid*, and the hydrophilic gum**, produced the most consistent and satisfactory results, the psyllium seed derivative* proving the more effective. The oil-agar emulsion†, was actually less satisfactory than the oil alone.

No untoward effects occurred in the group of patients studied. It should be pointed out however, on the basis of our use of mucilloid in other patients that there are certain instances in which it is undesirable to increase the bulk of the stool. Patients with any significant rectal lesions, such as fissures or fistulae, react unfavorably if the bulk of the stools is unduly increased. Obstructing bowel lesions also constitute a contraindication for the preparation.

It is our belief that any hydrophilic preparation by itself is not a complete substitute for the commonly accepted principles of bowel management, but certainly must be considered as a valuable adjunct to a well-balanced bland diet, the administration of antispasmodics, adequate fluid intake and regularity of the bowel habit.

*Metamucil, G. D. Searle & Co., Chicago
**Bassoran, Wm. S. Merrell Co., Cincinnati, Ohio
†Petrogalar, Wyeth Inc., Philadelphia, Pa.

SUMMARY

Twenty-nine patients who complained of constipation and had an irritable bowel syndrome were studied under controlled conditions to determine the effect of five types of laxatives or bulk forming preparations on their respective bowel habits and abdominal discomfort. The most satisfactory results were obtained with the hydrophilic mucilloid* prepared from psyllium seed, the next best with a hydrophilic gum** and then, in the order named, with liquid petrolatum, liquid petrolatum and agar†, a bland diet and saline cathartics.

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If tuberculosis is to be eradicated, extensive collaborative research, firmly directed, adequately financed, and carried forward by the teamwork of many men, must be initiated in even larger measure. Pub. Health Rep. Ed., April 5, 1946.

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If the public health nurse understands the tuberculosis patient, she will better understand all human beings. Elizabeth A. Murrish, R.N. Public Health Nursing, May 1946.

# PSYCHIATRY IN THE ILLINOIS STATE TRAINING SCHOOL FOR BOYS

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This paper is presented to describe the role of the psychiatrist and to outline the scope of psychiatry in a Training School for delinquent boys.

Let us start by considering the delinquent for whom the school is maintained. Who is he? One first thinks of a youngster, who violates existing community laws and defaults against social and moral standards. On closer scrutiny, it becomes apparent that this is not a qualitative, but at best only a quantitative distinction from a so-called normal child. What "normal" child has not yielded to temptations like truancy, stealing, aggression against members of his family or escape from unpleasant situations at home? Many a youngster's first experience in the sexual area is factually identical with those of delinquents charged with statutory rape or contributing to the delinquency of a minor.

The "delinquent" child differs from the normal in that he continually perpetuates and repeats his offenses, while the "normal" child "learns his lesson" from such experiences. Apparently a "normal" child possesses and a "delinquent" child lacks certain factors which prevent him from continuing generally disapproved actions. These factors may be found within the child, like feelings of guilt, conscience, superego, or they may appear as outside influences like the corrective influences of family setting and community organization. Besides lack of internal deterrents against offending, special attractions or rewards may be held out for the offender such as in the cases of gang delinquents who gain status and recognition through acceptance into the gang, or such as the boy who, due to deepseated feelings of guilt, has a need for punishment and receives emotional gratification in a masochistic manner.

Presented before the Physicians' Association, Department of Public Welfare, State of Illinois, in conjunction with the 106th Annual Meeting of the Illinois State Medical Society, Chicago, May 14, 1946.

I would like to emphasize here the position in the family or in the communal organization in which the juvenile offender finds himself. Is he considered as a "black sheep" of the family because of his long record of misbehavior and incompatibility or is his behavior the consequence of the position which the family by arbitrary and accidental means has provided for him? Every member in a group setting lives up to the position he is thrust into, much more so a child who is unusually suggestible and has not formed any definite patterns.

Similarly, many contacts with law enforcing agencies in the community mark a child for a career as a delinquent. Rather than anti-social behavior, one may consider the delinquent activity an effort of the child to remain socialized by accepting the position that family and community have provided for him.

One example to illustrate the importance of such social and legal influences is:

Carl, a colored boy, aged 13, had run away from a seemingly inadequate home on the West Coast. He was picked up in Chicago after he ran out of funds and applied to the Travelers' Aid for help in reaching his destination. He was kept at the Juvenile Detention Home for six months, and since no cooperation from the members of his family could be secured, he was committed to the Training School. Carl recently became very disturbed when a teacher asked him in front of the class for the reason for his commitment. When seen by the psychiatrist, he stated that he hated to admit that he was committed *only* for running away from home. He feared the other boys' ridicule since he had given them the impression that he had committed car larceny. Carl only verbalized such delinquent actions, but he might have felt readily impelled to carry them out if such pressure continued.

Let us look at the delinquent from another angle! It is my impression that every child has delinquent tendencies and wishes; he learns to become non-delinquent or "normal" by digesting and utilizing such delinquent impulses whether expressed overtly or only in fantasy. Thus, by a trial and error method he develops strong enough internal deterrents against outward expression of anti-social acts.

In education within the family and community, restrictive and punitive approaches have been the standard methods of the past. Applied

to the juvenile offender, these methods have proved inadequate and ineffective in preventing an anti-social career[1]; actually they have driven delinquents to follow an anti-social career.

In the case of the juvenile law offender, restrictive and punitive approaches have preceded the commitment to a training school by a long time and have given symptoms a predominant importance, outweighing and covering up basic underlying pathology. The mere fact of commitment indicates that the delinquent child has become refractory to authoritarian, restrictive, and punitive approaches.

Any boy not prevented from a criminal career becomes a serious and expensive community problem. Also, through his leadership and by identification, he will be a source of criminal contacts for other boys. This is a challenge to establish rehabilitation procedures as thorough and effective as possible and to furnish elaborate research facilities for those offenders who do not respond to our present day methods of treatment.

What resources do we have in the training school to attack the basic fundamental conditions of the delinquent?

Obviously a correct and thorough diagnostic evaluation is imperative if we are to employ adequate therapy. Realizing these needs, we established a diagnostic clinic at St. Charles in accordance with the principles of a child guidance clinic. Since December 1945, we studied all newly committed cases. Following a system of classification described by Williams[2], we found the following data in our four months of operation, with 190 boys.

The *situational category* consists of boys who have not yet developed strong delinquent patterns by community stigmatization and may be considered as average youngsters who are caught in "normal" adolescent delinquent acts. Twenty per cent of our boys fall into this category; we recommend for them immediate separation from the Training School program to avoid deepening of the stigma of the delinquent. Due to the clinical psychiatric facilities of the Juvenile Court and other agencies, few boys of this category are received from Cook County, Chicago.

By far the largest percentage (38%) makes up the *personality category* which consists of boys who became delinquent because their delinquency symptomatically, symbolically, or vicariously fulfilled some deep-seated emotional needs. Boys of this category need intensive psychiatric study to establish the connection between the emotional disturbance and the delinquent symptoms, and to find some solution for the emotional problems after they are discovered.

Fifteen per cent of our cases fall into the *asocial category* which parallels the psychiatric diagnosis of constitutional psychopathic inferiority.

Twenty-four per cent fall into the *pseudo-social category* which consists of boys who have, by identification with family or anti-social groups, accepted anti-social attitudes.

The last category, comprising three per cent, consists of the *medical category.* Here the major need for help lies in the medical area. We have reason to believe that the percentage of this group would be larger if we had more adequate clinical and laboratory facilities.

What use is made of the findings of the diagnostic clinic? We recommend administrative procedures and formulate a plan of intergration for each boy into the Training School. This requires thorough acquaintance with the different areas and the qualifications of each available employee. We pay special attention to careful placement of boys with such employees among our personnel who would be suitable and capable to accept and respond to a delinquent boy's underlying emotional needs.

Comparing our offender with a patient in a hospital, it is surprising to see how little positive accepting attention is paid to his symptoms — the delinquent actions. There exist numerous rules in the Training School which make offenses of certain practices which in general society are common; for instance, smoking on the grounds, talking during meals or while marching in formation. Violations are readily noticed and usually immediately suppressed. Little interpretation is given of the dynamics involved in violating such rules which exist primarily for the benefit of the employees.

Any expression of delinquent plans among boys is frowned upon and prohibited. Most employees are unable to discuss delinquent symptoms with their charges and frequently become disturbed and resentful if other workers discuss

delinquent actions objectively. When a boy enters the program, he receives the impression that his treatment and further progress at the school will depend chiefly upon his conduct while at the school regardless of his previous experiences.

St. Charles has a well-established academic school, a training program in different vocations, a home life training program, diverse recreational activities, and military drill. There are no provisions in the boy's general program for an adequate, direct approach to the problem of delinquency and its underlying sources. It is as if in a general hospital we subjected all incoming patients to identical therapeutic porcedures, kept them for a certain length of time, and discharged them disregarding their condition.

Why is a direct approach frowned upon so much by the average institutional employee?

The answer lies in his own deep-seated mental conflicts. The average employee distinguishes himself from the delinquent boy by the fact that he has developed strong enough inhibitive barriers against the expression of his unconscious "delinquent" impulses which frequently are just as strong as those of the delinquent. Whenever "delinquent" behavior is expressed by others deep-seated feelings of guilt are activated. A feeling of frustration results which finds expression in a punitive attitude. Apparently many of the offenses committed by boys in the Training School are much more of an internal than an external threat to the average adult employee. This is just as true of the relationship between a socialized child and his parents as between a delinquent child and the individual in charge of him. One example might illustrate this point:

One of our employees was obviously concerned about one of his charges whom he had observed indulging in seemingly excessive masturbation. "Do you think he knows what that is leading to?" he asked me, and on further inquiry: "to softening of the brain, don't you know?" In the ensuing discussion considerable feelings of guilt about previous masturbation as well as excessive tension and anxiety in his fight for control of masturbation were elicited.

In order to develop a staff of employees who are capable of dealing with boys on an unbiased, unprejudiced and emotionally mature level, a careful selection of employees and a continued in-service training program appear necessary. Since most employees are recruited from persons without any professional training, the first handicap to be overcome is their resistance and antagonism toward a professional approach due to their feelings of inadequacy and inferiority. The employee all too frequently gives lip service to a progressive mental hygiene program while putting into practice deep-seated convictions that are diametrically opposed. This discrepancy will be the more pronounced the more authoritatively the mental hygiene principles are applied. It has been my experience that much more can be accomplished by the establishment of an accepting, understanding and personal relationship with an employee rather than by written or oral orders. In this way a genuine interest in a progressive program can be created in the employee which frequently induces him to learn more about an improved approach. This procedure should also help form a unified staff with common objectives in a positive sense.

The treatment of the employees, especially that of the houseparents, is comparable to the treatment of parents in child guidance clinics aimed at the improvement of behavior disorders in their children. The emotional tension or relaxation in a cottage group of delinquent boys appears in direct proportion to the emotional security and stability of the houseparents.

The boys of the *personality category* can be successfully approached only through psychiatric techniques. Here the establishment of close interpersonal relationships is paramount, as this appears to be the only way to break through the defense the delinquent has built around his vulnerable inner personality. Rather than going into details of technique, I should like to present here an illustrative example.

Joe was committed to the training school for stealing purses out of women's pocketbooks. When first seen by the examiner, Joe stated that he did not know any reason for his stealing. It appeared that although on the surface he expressed much concern for his mother, this was a disguise of deep-seated feelings of hostility. After a period of an accepting relationship therapy, Joe was able to express considerable antagonism against his mother. He stated that he hated her since she had thrown away a toy which he had received as a gift from his father who was divorced from his mother. Joe connected the onset of stealing from his mother with that episode and spontaneously raised the question whether there was any connection between stealing from his mother and stealing of the purses. Although the explanation of the toy incident does not appear to be the basic pathology,

it indicates well the mutual attitudes in the family. Further therapeutic sessions should help him readjust to his mother and alleviate the guilt feelings toward her.

Through increased insight and emotional understanding, many delinquent boys can be helped to accept and gratify their basic needs by other than delinquent behavior. As some of these boys eventually outgrow their period of delinquency by a delayed natural maturing, treatment would accomplish a saving in the time of the training period. It should further inhibit the stabilization of delinquent patterns and thereby increase the recovery rate.

This therapy has to be given by a psychiatrist trained especially in child guidance procedures. In certain milder cases trained child guidance counselors may carry out such treatment under psychiatric supervision.

Since the number of boys in this group is large, amounting to approximately two hundred per year, the present staff of one psychiatrist is exceedingly insufficient for this portion of the training program alone.

Encouraging results were obtained with some children of this group by using group psychotherapy. A number of inhibited, withdrawn, and poorly socialized boys in a permissive group setting, emphasizing the social position of the different members within the group were treated. Results were reflected by better institutional adjustment and a more rational and direct approach to every day problems. This group is too small and too recent to furnish any information about readjustment in the community.

The *asocial offender* has so far shown the poorest results from treatment. Due to his basic inability to develop satisfactory interpersonal relationships, treatment by methods of transference fails. Williams[2] recommended this group for extensive study and therapeutic experimentation. According to Jenkins[3], treatment of these offenders should appeal to their self interest rather than to their loyalty.

Abrahams and McCorkle[4] have utilized an approach to military offenders by group emotional catharsis and analysis of behavior problems following the showing of visual aids. In these sessions the group therapist acts only as a "catalyst." The individual's defensive reaction against authority is utilized as group energy during the discussion. The authors claim surprising reduction of behavior problems during detention and improved adjustments after release. We have plans to establish a similar program especially for boys of the asocial category.

The extreme exponent of the asocial type appears not only unresponsive to treatment, but by his attitudes and group influence may become a serious threat to the continuity of a program. It may become necessary to sacrifice him for the welfare of the others.[5] We have dealt with such a case by transfer to the "security unit" at Sheridan, Illinois, which is a part of the Training School and equipped to house sixty boys. We have reserved this unit for the custodial detention of the aggressive delinquent. Thereby, it fulfills an important function in the overall program of the Training School.

The members of the *pseudo-social* category are boys that are well socialized but have been oriented to faulty standards, identifications, and idealizations. Their treatment needs reorientation through identification with strong leadership which can be supplied adequately by the Training School employees such as house-parents, teachers, etc. In order to accomplish this, it is important to know the emotional qualities of our employees and place the boys accordingly.

Considerable interest has been expressed by administrative officials for psychiatric views on general procedures planned. Since every phase of the Training School eventually effects the individual boy and may either aid or retard his social recovery, mental hygiene principles should be pointed out in all conditions effecting changes in routine procedures.

To assure continuity of treatment and to better evaluate results, a closer connection with community agencies dealing with delinquent children is indicated, especially probation and parole service. It would appear logical as previously recommended to combine these functions with that of the Training School under a state-wide program of delinquency treatment. This would be a basis for the development of a strong and continuous interpersonal relationship between the delinquent and his therapist, whether a probation or parole officer or a counselor at the Training School. It is my impression that the

more the probation or parole officer is relieved of his authoritative police functions the more his value in basically "reforming" delinquents will increase and his role in the treatment of delinquency be more effective.[7]

This emphasizes a need for much closer cooperation between the Training School and the community. Just as many "pre-delinquents" may be prevented from becoming delinquents by an intensified community program as, for example, the Chicago Area Projects,[8] acceptance of the Training School and its program by the community will decrease the stigmation of the offender and provide him with a better chance for adjustment on parole.

Much public education is necessary to decrease the stigma of delinquency and to bring the public to consider the "delinquent" as a socially ill person. As accomplished in recent decades in the conception of mental illness, a reorientation should be propagated likewise in our thinking about the "socially ill."

*Summary:* 1. Sufficient clinical diagnostic facilities should be provided for individual study. Material obtained in these studies should be utilized for statistical analysis and research in therapy.

2. There is a definite need for active psychiatric and group treatment of a large majority of boys who are treatable. Resistive cases should be subjected to experimentation with new techniques. If their influence seriously disrupts the training program, administrative elimination is recommended.

3. Since every employee working with boys exercises a strong favorable or unfavorable influence, careful selection of new employees and individual attention to their own emotional needs should be given.

4. Much closer contact should be maintained between the Training School and different organizations interested in the treatment of delinquency. Special efforts should be made to assure the community acceptance of individual boys and the training school program as a whole.

5. Continuous public education emphasizing that delinquency is a symptom of a socially ill person, and assistance to the public to provide adequate means of satisfying the needs of these persons is recommended.

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## DISCUSSION

Dr. R. Jenkins, Springfield:

To one who has not actually worked in a training school it is perhaps difficult to realize how much sense, skill, and experience is packed into Dr. Marx's brief paper.

Nominally, the program of the modern training school is one of rehabilitation. Actually, it is extremely difficult to maintain the treatment point of view. The practice of weighing measures by their effect upon the boy, in the face of the repressive philosophy dominant in our society and traditional in our training schools. One cannot challenge this philosophy too directly. A training school is always a potential powder keg. There is always collected within it an aggregation of hostility, resentment, rebellion, and bitterness toward society which cannot be cured with a few doses of the milk of human kindness. This hostility and rebellion is ready to break forth at any sign of weakness or confusion on the part of the administration. One cannot safely remove the controls from the aggregation of hard-bitten, unhappy, and often distorted personalities which have been collected in a training school. Preservation of control is necessary, yet the traditional repressive measures by which control is preserved, unless handled with unusual skill, are likely to intensify rather than to reduce the problem of rehabilitation. Small wonder that the untrained staff commonly see the treatment philosophy as a threat to themselves and their safety. And in event of any untoward development, their clamor for severity is immediately taken up by the surrounding community and thrown into headlines by such eternal and powerful advocates of a repressive philosophy as the Chicago Tribune.

Yet, the healing profession has a responsibility with respect to minds and personalities no less than with respect to bodies. In seeking a program of rehabilitation, the program centers not so much on difficulties of working with the boys as on difficulties of making such a program thoroughly accepted by the staff. It is necessary to be a missionary without seeming to be

one, to work with the personal problems and attitudes of staff members while maintaining an even footing and a friendly relation. Training schools are not under medical control, nor are the problems they treat generally regarded as problems for the psychiatrist. However sympathetic to a psychiatric point of view the superintendent might be, the rank and file of the staff must be *won* to a treatment philosophy.

It is necessary, therefore, to proceed slowly, without recourse to authority except in the area of physical illness or the rare cases of frank psychosis where medical authority is unchallenged. It is necessary to seek the gradual permeation of a rigid and tense social institution with a more flexible, resourceful philosophy, dominated by consideration of social rehabilitation rather than mere repression or vengeance. The appeal must be made to individual staff members in terms of the needs of boys in whom they have developed a human interest. This is a difficult, slow process, the achievement of which is of tremendous importance for the ideals of the healing profession in particular and of democracy in general.

I should like to congratulate Dr. Marx on his constructive discussion of this problem, which to me indicates unusual success in meeting it.

## ALLERGY DRUG PRESENTS SERIOUS INDUSTRIAL HAZARD—DROWSINESS

### Machine Operators, Automobile Drivers Warned Of Narcotic Effect Benadryl Produces

Two Rochester, N. Y., doctors warn that benadryl, a very effective drug for allergic skin diseases, is dangerous to persons operating any kind of machine, especially an automobile, because it may produce drowsiness, according to an article in the September 28 issue of *The Journal of the American Medical Association*.

Benjamin J. Slater, Associate Medical Director, Eastman Kodak Co., and Nathan Francis, of the Medical Deparment of the Eastman Kodak Co., in Rochester, state that "because of this narcotic side reaction incident to the taking of benadryl, the drug may be a serious hazard when used by persons operating automobiles or in industry operating moving equipment or machinery."

In their series of 65 cases, the authors point out that drowsiness was a common symptom in 25. "This figure should be increased somewhat," they say, "as many of our patients were instructed to take the drug only at bedtime. Invariably they reported that they slept better than usual. Drowsiness may occur from one to three hours after taking benadryl, and this drowsiness may be cumulative if the drug is continued."

A case report of one of their patients serves to illustrate how dangerous the effect of the drug may prove. A 20 year old man was given a 50 milligram capsule of this drug to relieve severe symptoms of hay fever. The second day of treatment he took the capsule just before going to work. He complained of feeling drowsy. An hour later, while driving an electric platform cargo truck, he lost control of the truck and it fell off the platform. Fortunately, he jumped in time to avoid injury.

# News of the State

## PERSONALS · COMING EVENTS · MARRIAGES · DEATHS

### ADAMS COUNTY

Dr. Harold Swanberg of Quincy, Editor of the Mississippi Valley Medical Journal and organizer of the Mississippi Valley Medical Society in 1935, was awarded the Distinguished Service Award by his Society for 1946. The award consisting of a gold medal and certificate, was presented to Dr. Swanberg at the recent meeting of this Society held in St. Louis, the presentation being made by the president, Dr. Grayson Carroll of St. Louis University.

### CHAMPAIGN COUNTY

Max H. Fisch, chief of the medical history division, Cleveland branch of the Army Medical Library, has been appointed professor of philosophy at the University of Illinois, Urbana.

### COOK COUNTY

St. Luke's, Grant and Children's Memorial Hospitals were among winners in the public education contest of the Illinois Hospital Association.

Awards were based on scrap-books of publicity and other material informing the public of the hospital's work.

Other winners were the Community Hospital, Geneva, and the Silver Cross Hospital, Joliet.

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Dr. J. P. Greenhill addressed the Wisconsin State Medical Society on October 8th, subject, "Endocrine Therapy in General Practice."

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Dr. Robert R. Mustell addressed the Junior Group of the American Association of University Women in Chicago on October 16th. He discussed "The Family Doctor."

Dr. Mustell has also been invited to address the Married Peoples' Club of the Brainerd Community Church on November 13th, presenting the subject of "Socialized Medicine."

Dr. Paul Roberts Cannon, chairman of the department of pathology of the University of Chicago, and Dr. Josiah J. Moore, director of the Moore Clinical Laboratory, have been named to the medical and scientific advisory council of the National Arthritis Research Foundation.

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On October 11th, Dr. James P. Simonds spoke on "The Pathologic Basis of the Clinical Manifestations of Nephritis" in the series of lectures presented by Fellows of the Institute of Medicine of Chicago.

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Two appointments to the staff of the University of Illinois College of Medicine have been announced. Dr. Roger A. Harvey, Rochester, N. Y., has been appointed professor and head of the department of radiology and Dr. David Shakow, New York, professor of psychiatry. Dr. Harvey is a former fellow of the International Cancer Research Foundation. In addition to his teaching duties, Dr. Shakow will serve as chief psychologist for the Illinois Neuropsychiatric Institute and director of the psychological laboratories in the medical school's department of psychiatry.

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Dr. Andrew C. Ivy, vice president of the Chicago Professional Colleges, University of Illinois, announced his resignation, September 24, from the Midwest Science and Technology Division of the Independent Citizens Committee of Arts, Sciences and Professions. He was a member of the executive committee of the science division. Dr. Ivy is reported to have said that the committee made moves which were "decidedly contrary" to his views and that he objected particularly to the committee's support of "compulsory health insurance." Instead he favors a sliding scale based on income to subsidize expensive medical care items.

Dr. Italo F. Volini, professor and head of the department of medicine, Loyola University School of Medicine, has been named a member of the School Board of the city of Chicago.

The Institute of Medicine of Chicago presented the first William Allen Pusey Lecture on October 25th at a meeting with the Chicago Dermatological Society and the Chicago Society of Internal Medicine. Dr. Udo J. Wile, Ann Arbor, spoke on "Some Obscure and Paradoxical Problems of Syphilis."

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Dr. Hugh J. Jewett, assistant professor of urology, Johns Hopkins University School of Medicine, Baltimore, delivered the annual William T. Belfield Memorial Lecture before the Chicago Urological Society, October 24, on "Bladder Tumors."

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The Chicago Medical Society held their first scientific meeting of the season on October 16 with Dr. A. C. Ivy speaking on "Nazi War Crimes of a Medical Nature."

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Dr. P. R. Blodgett, recently discharged from the navy after 21 months' service, has resumed the practice of medicine in Chicago Heights. His re-appointment as city health officer was confirmed recently by the city council.

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The appointment of Dr. Frederick C. Lendrum, assistant professor of medicine, as director of the reorganized and expanded health service of the University of Illinois' professional colleges in Chicago has been announced.

Dr. Lendrum succeeds Dr. Edward Hurtado, who has resigned to return to private practice. The new Health Service Director's Staff includes Dr. Joseph H. Filip, recently returned from army service in the ETO and Philippines, and Dr. Eslie Hartman, women's physician.

Functions of the Health Service fall into three categories: (1) Medical attention for on-the-job injuries of faculty and staff, (2) examination of new students and employees, (3) examinations legally required in connection with sick benefits and the university's retirement system.

Service facilities, now being greatly expanded after the part-time arrangement in effect during the war, will be integrated with the teaching, research and treatment programs in the professional colleges, the hospitals, and the clinics.

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Dr. Arthur F. Abt, associate professor of pediatrics in the Northwestern University Medical School, has been appointed consultant in pediatrics at the United States naval hospital at Great Lakes. The hospital's pediatrics department provides care for children of navy personnel in the 9th naval district.

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Dr. John S. Gray, professor of physiology, has been appointed chairman of the department of physiology of the Northwestern University Medical School, it has been announced by President Franklyn B. Snyder.

Dr. Gray, who has been a member of the medical faculty since 1934, is a specialist in gastrointestinal physiology, endocrinology, respiration, and aviation physiology. During the war, from 1942-45, he was a research physiologist with the army air forces, School of Aviation Medicine, Randolph Field, Texas.

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The 90th session of the Northwestern University Medical School was opened Tuesday morning, October 1st, with the Annual Founders' Day convocation held in the Archibald Church Library. Dean J. Roscoe Miller presided at the gathering of faculty and students, and introduced Dr. Barry J. Anson, professor of anatomy, who presented the address entitled, "Saints, Animals, the Stars and Demons in Mediaeval Medicine."

Also, for the second time since they were established by the late Dr. George James Dennis, the Phi Rho Sigma Scholarship Awards were presented. The presentations were made by Dr. Howard B. Corroll, president of the Alpha Association of Phi Rho Sigma Medical fraternity.

The first award, consisting of a $100 U. S. Government bond and a certificate of recognition, given to the student who has maintained the highest scholastic average during his first three years of medicine at Northwestern, was presented to Mr. Sheldon S. Waldstein. The second award, consisting of a framed certificate, offered to the national medical fraternity at the medical school having thirty or more active members enrolled as regular students which has maintained the highest scholastic average during the preceding year, was given to Phi Beta Pi. The third award, consisting of a $50 U. S. Government bond and a certificate, given to the man in the winning fraternity who has been chosen by his fraternity as the student to have contributed more toward winning the award, went to Mr. Edward N. Tihen.

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Dr. David Slight, former head of the department of psychiatry at the University of Chicago, delivered a series of three lectures on "Mental Hygiene" at the Ridge Park Field House, Chicago.

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At the Annual Meeting of the American College of Chest Physicians held at San Francisco

last spring, Dr. Minas Joannides, Chicago, was elected the Secretary-Treasurer of the College.

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Dr. Kenneth W. Thompson has resigned as managing editor of the Journal of Clinical Endocrinology.

The Publications Committee of the Association for the Study of Internal Secretions has announced the appointment of Dr. Willard O. Thompson, Chicago, as the new managing editor.

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The Chicago Surgical Society prize of $250.00 will again be awarded in 1947 to some young man devoting himself to surgery in Cook County, who is not a member of the Chicago Surgical Society, for meritorious work in the fields of experimental and clinical surgery (either or both). The work must be original, with original illustrations, and the paper should never have been read or published anywhere in its final form. Papers should have no identifying marks other than the title. They should be accompanied by a sealed envelope bearing the title only. Within the envelope should be the title and the name and address of the author. The material to be considered should be submitted to the chairman of the committee, Dr. Michael Mason, 154 East Erie Street, Chicago, Illinois, on or before March 1, 1947.

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## DEWITT COUNTY

Dr. Keith Rhea has opened his new offices on east Main Street in Clinton for the practice of medicine.

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Dr. H. L. Meltzer has returned to his office after a three weeks' vacation spent in Colorado.

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Dr. Charles W. Carter has recently been elected to the Fifty Year Club by the Council of the Illinois State Medical Society.

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The members of the County Medical Society are cooperating in the effort to get a local health unit for DeWitt and Piatt Counties. The proposition is to be voted upon at the November election.

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The DeWitt County Tuberculosis Association made their annual tuberculosis tests of the seniors in the six county high schools on October 8.

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## FORD COUNTY

Dr. John A. Colteaux of Roberts and Dr. W. R. Cohlan, of Chicago, are associated in the practice of medicine and surgery in Roberts. Dr. Cohlan served in the army medical corps in the South Pacific for three and one-half years.

## FULTON COUNTY

Dr. E. P. Coleman, Canton, was the dinner speaker at the annual meeting of the Executive Board and guests of the Illinois Statewide Public Health Committee at the Stevens Hotel, Chicago, on September 27.

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## KANKAKEE COUNTY

Dr. Donald A. Meier has opened an office in St. Anne for the practice of medicine. Dr. Meier was discharged from the army in January after serving more than four years.

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## LA SALLE COUNTY

A post-graduate conference was held in La Salle on October 24 with the following Chicago doctors participating:

Dr. William S. Hoffman — "Clinical Use of Amino Acids in Protein Deficiency"

Dr. Samuel M. Feinberg — "Treatment of Allergic States with Special Reference to the Histamine Antagonists"

Dr. Edward Allen — "Endometriosis"

Dr. Frank G. Murphy — "Common Fractures"

Dr. Willard Owen Thompson — "Recent Developments in the Treatment of Toxic Goiter"

Dr. Jerome R. Head — "Surgery of the Lung"

Dr. George A. Hellmuth — "Coronary Disease"

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## LOGAN COUNTY

Dr. Harlan English, Danville, will address the Lincoln Woman's Club for the Logan County Medical Society Auxiliary Laity Day program on December 4th. He will discuss "Some Problems Confronting the Medical Profession."

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## McLEAN COUNTY

Dr. George W. France, LeRoy physician since his release from the army medical corps, was presented with a bronze medal and citation by direction of President Truman at his home in LeRoy recently. Capt. France served as chief of a shock team in the European theater of operations. He was cited for commendable performance of duty which resulted in the saving of many lives of patients who received treatment for shock under his direction.

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## MACOUPIN COUNTY

The Macoupin County Medical Society held a scientific meeting on September 24th at Carlinville with Dr. Keith S. Wilson of the Washington University School of Medicine, St. Louis, Mo., as guest speaker. Doctor Wilson gave an illustrated talk on "Penicillin Therapy."

Dr. Otto Hauser who has practiced medicine in Mt. Olive over 40 years has retired from active practice. Dr. Frank Warner, recently discharged from the army medical corps after three years' service, has purchased Doctor Hauser's equipment and opened an office in the rooms formerly occupied by him in Mt. Olive.

## MACON COUNTY

A Post-Graduate Conference was held in Decatur on October 22nd with the following Chicago doctors presenting the program:

Dr. J. D. Farrington — "Common Fractures"
Dr. Lindon Seed — "Prophylactic Use of Chemo-Therapy in Abdominal Surgery"
Dr. Samuel Henry Kraines — "Shock Treatment for the Psychoses"
Dr. Henry T. Ricketts — "The Medical Treatment of Hyperthyroidism"
Dr. Robert S. Berghoff — "Some Problems Facing the Medical Profession"
Dr. M. Herbert Barker — "Management of Hypertension.

## PEORIA COUNTY

Dr. Leonard C. DeLozier, ear, nose and throat specialist, has opened an office in Peoria. A graduate of Northwestern University Medical School, he practiced several years in Chicago before serving 41 months with the navy in the United States and southwest Pacific.

Dr. Richard J. Graff, Lincoln, was recently appointed superintendent of the Peoria State Hospital.

## ROCK ISLAND COUNTY

Dr. Howard A. Lindberg, Chicago, has been invited to address the Rock Island County Medical Society on January 14th, subject, "Pneumonia."

## SANGAMON COUNTY

Dr. Robert K. Campbell, Springfield, was elected Governor of the American College of Chest Physicians at their Annual Meeting in San Francisco.

## WILL-GRUNDY COUNTY

Dr. Philip Thorek will present the scientific program before the Will-Grundy County Medical Society on November 14th. He will talk on "Intestinal Obstruction."

## WILLIAMSON COUNTY

Dr. Wayne P. Sirles has reopened his offices in Herrin and will limit has practice to treatment of eye, ear, nose and throat patients.

## MARRIAGES

George H. Cech, Berwyn, Ill., to Miss Florence C. Jones of Western Springs, Ill., May 4.

## DEATHS

Roy Frank Barker, Wood River; Barnes Medical College, St. Louis, Mo., 1907. Had practiced medicine 30 years in East St. Louis and moved to Wood River six years ago. Died of a heart attack, Sept. 11th, while at the home of his brother in Alton. He was 61 years of age.

Soddie J. Barkett, Hayworth; University of Illinois College of Medicine, 1940. Suffering from despondency following his discharge from the army, he took his own life Aug. 19th while doing post-graduate work in Chicago. He was 32 years of age.

Walter C. Bisson, Charleston, retired; Chicago Homeopathic Medical College, 1903. Served in the medical corps in World War I. Died Oct. 1st, aged 72.

Sanford Milton Blunk, Virden; University of Illinois College of Medicine, 1911. Had practiced medicine in Virden for 34 years. Died in St. John's hospital, Springfield, Sept. 8th, following an illness of several weeks. He was 68 years of age.

Franklin W. Blye, Chicago; University of Illinois College of Medicine, 1925. Had practiced medicine in Chicago's Hyde Park for 20 years. Died of a heart ailment in his home, Sept. 21st, at the age of 48.

Robert Deward Clark, Alton; Emory University School of Medicine, Atlanta, 1928. Member of the West Virginia State Medical Association. Died in a hospital at Beckley, W. Va., July 12th, aged 47, of coronary thrombosis.

Mary Victoria Wolf Dryden, Aledo; Northwestern University Woman's Medical School, 1898. At one time affiliated with the Battle Creek (Mich.) Sanitarium. Died July 27th, aged 78, of arteriosclerosis with renal disease.

Mordecai L. Howard, Danville; Pulte Medical College, Homeopathic, Cincinnati, 1891. Born and reared in DeWitt County, he had practiced medicine in Danville for many years. Died Sept. 17, aged 91.

Lawrence Leslie Irwin, Bloomington; St. Louis University School of Medicine, 1907. Died of subarachnoid hemorrhage in St. Joseph's hospital, Sept. 17th, aged 61.

Samuel Wheeles McKelvey, Belleville; Washington University School of Medicine, 1913. Served as president of the Belleville Township High School of Education. In 1941 appointed consulting surgeon for state hospitals at Alton and Jacksonville. Died Sept. 7th, aged 56, of poliomyelitis.

James A. Poling, Freeport; Northwestern University Medical School, 1893. Had practiced medicine in Freeport over 50 years. Was the first chief of the medical staff at St. Francis hospital, a 32nd degree Mason of Evergreen lodge, former city health commissioner and a district health officer for 8 years. Died at a Moline hospital, Sept. 14th, aged 79.

James L. Ranes, Jacksonville; Barnes Medical College, St. Louis, 1905. On the staff of Jacksonville State Hospital. Died in the Passavant Hospital, July 17, aged 72, of coronary occlusion.

Pleasant W. Rose, Cypress; Barnes Medical College, St. Louis, Mo., 1899. Had been physician and surgeon in Cypress and vicinity nearly 50 years. Died suddenly in his home, Aug. 29th, aged 69.

John Kiyoski Shima, Joliet; Tulane University of Louisiana School of Medicine, New Orleans, 1939. Served an internship and residency at the St. Joseph Hospital, where he died July 31, aged 34, of virus pneumonia.

Ruth Tunnicliff, Chicago; Rush Medical College, 1903. She was a research worker in the John McCormick Institute for Infectious Diseases, and the Foundation for Dental Research, Chicago College of Dental Surgery; past president of the Chicago Society of Pathologists. Died of a heart attack in her home, Sept. 22nd, at the age of 70.

Robert Von Der Heydt, Oak Park; University of Illinois College of Physicians and Surgeons, 1903. Was associate professor of Ophthalmology, (Rush) University of Illinois College of Medicine, ophthalmologist to West Suburban, Presbyterian and Michael Reese Hospitals; past president of the Chicago Ophthalmological Society. For many years he was Ophthalmologist at the Illinois Charitable Eye and Ear Infirmary. Died in West Suburban Hospital Sept. 18th, aged 71.

George Albert Weirick, Elgin; Drake University College of Medicine, Des Moines, Iowa, 1908. Had practiced in Elgin 15 years, formerly in Hastings, Nebraska, and Rockford. Died in his home, Oct. 2nd, aged 84.

Ernest G. Wilson, Kankakee; Indiana Medical College, School of Medicine, Purdue University, Indianapolis, 1906. Had practiced medicine in Kankakee County for 40 years. Was member of the staff of St. Mary's Hospital, Kankakee, and vice-president of the hospital since 1931. Died in his home, Sept. 25th, aged 61.

## DOCTOR SAYS MEN HAVE CHANGE OF LIFE SIMILAR TO THAT OF WOMEN

A St. Louis doctor maintains that men have a change of life similar to that of women, according to the September 28 issue of *The Journal of the American Medical Association.*

August A. Werner, M.D., Assistant Professor of Internal Medicine at St. Louis University School of Medicine, describes the symptoms of the male climacteric as nervous tension, disturbed sleep, headaches, impaired memory, depression or mild melancholia, worry and loss of confidence.

There are also certain circulatory symptoms that manifest themselves in hot flushes, heavy breathing, rapid pulse and dizziness on change of position. Lassitude and fatigability are described as general symptoms.

The author states that he studied 273 men patients, 234 of whom had climacteric symptoms. The average age of this group was 53.7 years. A sex hormone, testosterone propionate, which the author claims is as effective in relieving the symptoms in men as estrogen is in relieving the symptoms of similar nature in women, was used for treating these patients.

Dr. Werner points out that in order to derive the greatest benefit from this treatment, the following steps are necessary:

Testosterone, in an oily solution, should be injected into the muscles in a 25 milligram dose.

For the first month or two the injections should be given every other day.

After the symptoms of the climacteric have been relieved for some time, the author finds it best to continue the injections at intervals of twice a week for one month, and then such injections given once a week are sufficient to keep the symptoms under control.

"The climacteric syndrome varies in duration in different persons," according to Dr. Werner. "It may last for from six months to five or six years or longer in some patients."

Following this procedure with 177 patients, the author found that 173 were benefited while four did not believe that they were helped.



# SOME ADVANTAGES

*of*

# Campbell's STRAINED BABY SOUPS

***Q. The edible solids of the meats are retained. Why?***

*A.* While the juices of meats contain valuable nutriments, the fibrous parts contain even more. In the preparation of Campbell's Strained Baby Soups the meats are prepared so that *all* of the edible solids as well as all the meat juices are retained to aid baby's growth and well-being.

***Q. The utmost precaution is used to retain natural flavors. Why?***

*A.* Every mother wants her baby's food to be palatable. Campbell's preparation and cooking methods have been devised to retain natural flavors as far as possible. Babies develop preferences early, accept some foods, reject others. Their acceptance of Campbell's Strained Baby Soups is indicated by the increasing demand for these soups wherever they have been introduced.

***Q. All the Vegetables get special handling. Why?***

*A.* Unless vegetables are prepared with the greatest of care and skill, they are likely to lose a large proportion of their valuable vitamins. Campbell's have developed a method, based on the latest scientific knowledge, which retains the minerals and efficiently conserves the vitamins.

A comprehensive analysis of each soup may be had upon application to Campbell Soup Company, Camden, New Jersey.

***5 KINDS:***

*CHICKEN*
*BEEF*
*LAMB*
*LIVER*
*VEGETABLE*

***All in Glass Jars***




Campbell's Strained Baby Soups represent fine quality . . . in ingredients . . . in care and method of cooking . . . in retention of minerals and conservation of vitamins . . . *and in good flavor.* Every resource of Campbell's Kitchens is devoted to that aim.




**LOOK FOR THE RED-AND-WHITE LABEL**

# DOES CANDY HAVE A PLACE IN THE SICK ROOM?



NOT only because of the "psychic lift" they give the patient, but also for their nutrient value, do many kinds of candy merit a place in the sick room.

Those, in the manufacture of which milk, butter, eggs, fruits, and nuts are used, contribute not only their contained calories but also small amounts of biologically adequate protein, fat high in unsaturated fatty acids, B vitamins, and minerals.

Such candies present no difficulty in digestion. Few indeed are the conditions when they might be contraindicated. Frequently they are readily eaten when the anorexia induced by inactivity makes the patient turn away from other foods.

Since candies present high caloric value in small bulk, they serve well in augmenting the patient's caloric intake.

## THE NUTRITIONAL PLATFORM OF CANDY

1. Candies in general supply high caloric value in small bulk.
2. Sugar supplied by candy requires little digestive effort to yield available energy.
3. Those candies, in the manufacture of which milk, butter, eggs, fruits, nuts, or peanuts are used, to this extent also—
   (a) provide bialagically adequate prateins and fats rich in the unsaturated fatty acids;
   (b) present appreciable amaunts of the important minerals calcium, phasphorus, and iran;
   (c) contribute the niacin, and the small amaunts of thiamine and ribaflavin, cantained in these ingredients.
4. Candies are of high satiety value; eaten after meals, they contribute ta the sense of satisfactian and well-being a meal shauld bring; eaten in maderatian between meals, they stave off hunger.
5. Candy is more than a mere saurce of nutriment—it is a marale builder, a contributian ta the joy of living.
6. Candy is unique among all faads in that it shaws relatively less tendency to undergo spailage, chemical ar bacterial.

**This Platform is Acceptable for Advertising in the Publications of the American Medical Association**

COUNCIL ON CANDY OF THE *National Confectioners' Association*

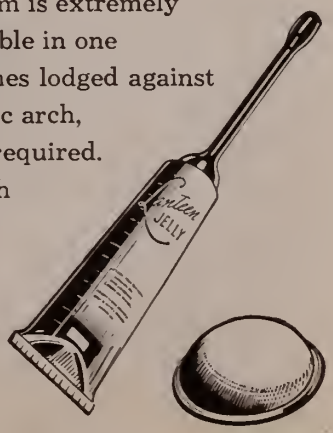
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# *Toward a Better World*




In sociological betterment, too, progress is being made, through Lanteen Medical Laboratories' promotion of Lanteen products. These leaders in their field are produced under the most rigid scientific standards.

*Proper placement* of the Lanteen Flat Spring Diaphragm is extremely simple. Patients require only brief instruction. Collapsible in one plane only, if the entering rim of the diaphragm becomes lodged against the cervix, the other rim cannot be forced into the pubic arch, when the *largest comfortable size* is used. No inserter required. Offered only to the medical profession . . . solely through ethical sources. Complete package available to physicians upon request.




**Lanteen**

LANTEEN MEDICAL LABORATORIES, INC • CHICAGO 10

WHENEVER

*Impaired Fat Digestion*

MUST BE OVERCOME

Impairment of fat digestion implies more than loss of available caloric food energy to the organism. It involves the failure of absorption of the fat-soluble vitamins A, D, E, and K, together with the development of deficiency manifestations. Particularly severe is vitamin K deficiency with prolongation of the prothrombin clotting time and the consequent hemorrhagic diathesis.

Whenever impaired fat digestion must be corrected, Degalol is specifically indicated. Degalol—chemically pure deoxycholic acid, a normal constituent of human bile — represents the biliary component chiefly concerned with fat digestion and absorption. Its administration in small dosage virtually normalizes fat digestion within the small bowel when lipase is not deficient, and with it absorption of the fat-soluble vitamins D, E, and K, and carotene. It is especially valuable in correcting the hemorrhagic complications of obstructive jaundice, where choleresis is undesirable. Degalol proves useful whenever impaired fat digestion is suspected, and particularly in the treatment of postprandial epigastric distress and fat intolerance not associated with chronic gallbladder disease. Supplied in tablets of 1½ gr., boxes of 100 and 500.

**Degalol**

REG. U. S. PAT. OFF.

CHEMICALLY PURE DEOXYCHOLIC ACID

**Riedel-de Haen**

DIVISION OF AMES COMPANY, INC.

NEW YORK 13, N. Y.

# efficient, low-dosage treatment of ulcerative colitis with

# 'Sulfathalidine'

***Phthalylsulfathiazole***

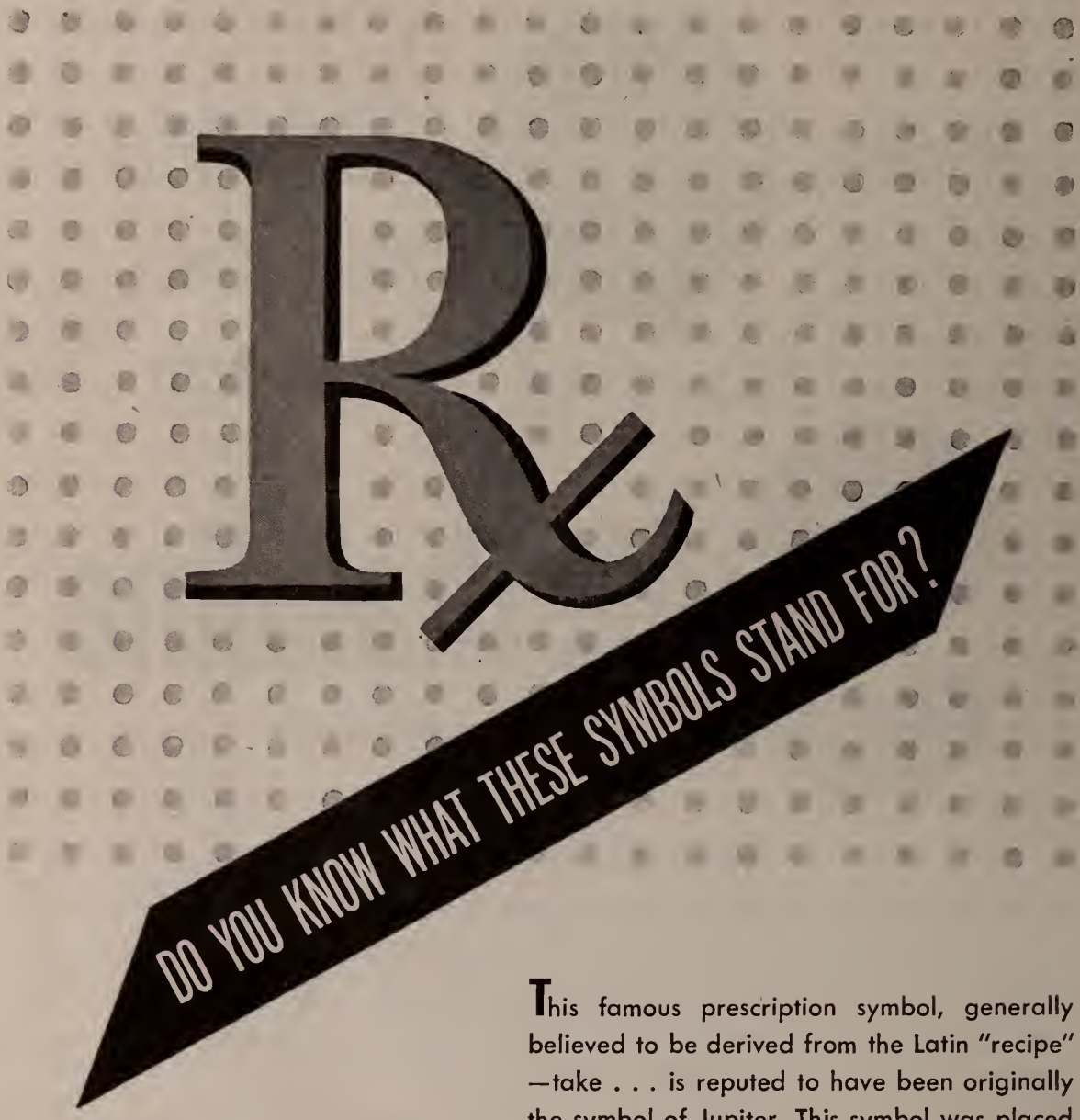
This *nontoxic, low-dosage*, enteric sulfonamide is exceptionally effective against acute and chronic ulcerative colitis, and recently proved successful in the treatment of 76 out of 80 patients[1] with this disease. After therapy with the drug, stools become formed and odorless, blood in stools disappears, cramping in abdomen subsides within 48 hours, and evacuations are reduced substantially.[2]

'SULFATHALIDINE' *phthalylsulfathiazole* is indicated also in the treatment of regional ileitis, as a supplement to the therapy of amebiasis, giardiasis and paratyphoid infections, and as an adjunct to intestinal surgery.

'SULFATHALIDINE' *phthalylsulfathiazole* maintains a *high bacteriostatic concentration* in the gastrointestinal tract (1250 mg. per cent). An average of only 5% of the drug is absorbed from the bowel and this is rapidly excreted by the kidneys. Administered in daily doses of only 0.05 Gm. to 0.1 Gm. per kilogram of body weight. Supplied in 0.5-Gm. compressed tablets in bottles of 100, 500 and 1,000. Sharp & Dohme, Philadelphia 1, Pa.

1. J.A.M.A. *129*:1080, Dec. 15, 1945
2. Illinois M. J. *88*:85, August, 1945

SHARP & DOHME




This famous prescription symbol, generally believed to be derived from the Latin "recipe" —take . . . is reputed to have been originally the symbol of Jupiter. This symbol was placed at the top of a formula to propitiate the king of gods in order that the compound might act favorably.

Almost as famous, but rooted purely in science, is the 43-year-old Rexall symbol of dependable drug service—displayed in selected and conveniently located pharmacies throughout the nation. It is a sign that fine Rexall drugs and expert pharmacy are at your service.

Rexall
DRUGS

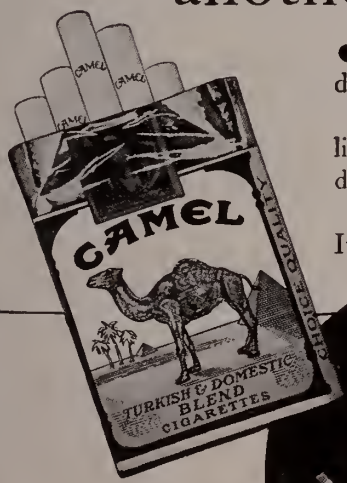
REXALL FOR RELIABILITY

**UNITED-REXALL DRUG CO.**
LOS ANGELES, CALIFORNIA

PHARMACEUTICAL CHEMISTS FOR MORE THAN 43 YEARS



# "Now Daddy's got to go to another 'birthday party,' Son..."




● Somewhere high in the sky the stork is racing. But the doctor will be at its destination first. Ready and waiting.

Whether bringing life or guarding it, the doctor's personal life fades into the background when duty calls. He is "on duty" every minute of every hour of the twenty-four.

But he isn't complaining. Or asking for any special credit. It's his job—and he does it.



R. J. Reynolds Tobacco Company, Winston-Salem, N. C.

**According to a recent independent nationwide survey:**

## MORE DOCTORS SMOKE CAMELS

***than any other cigarette***



## Now We Are Producing for Your X-Ray Needs

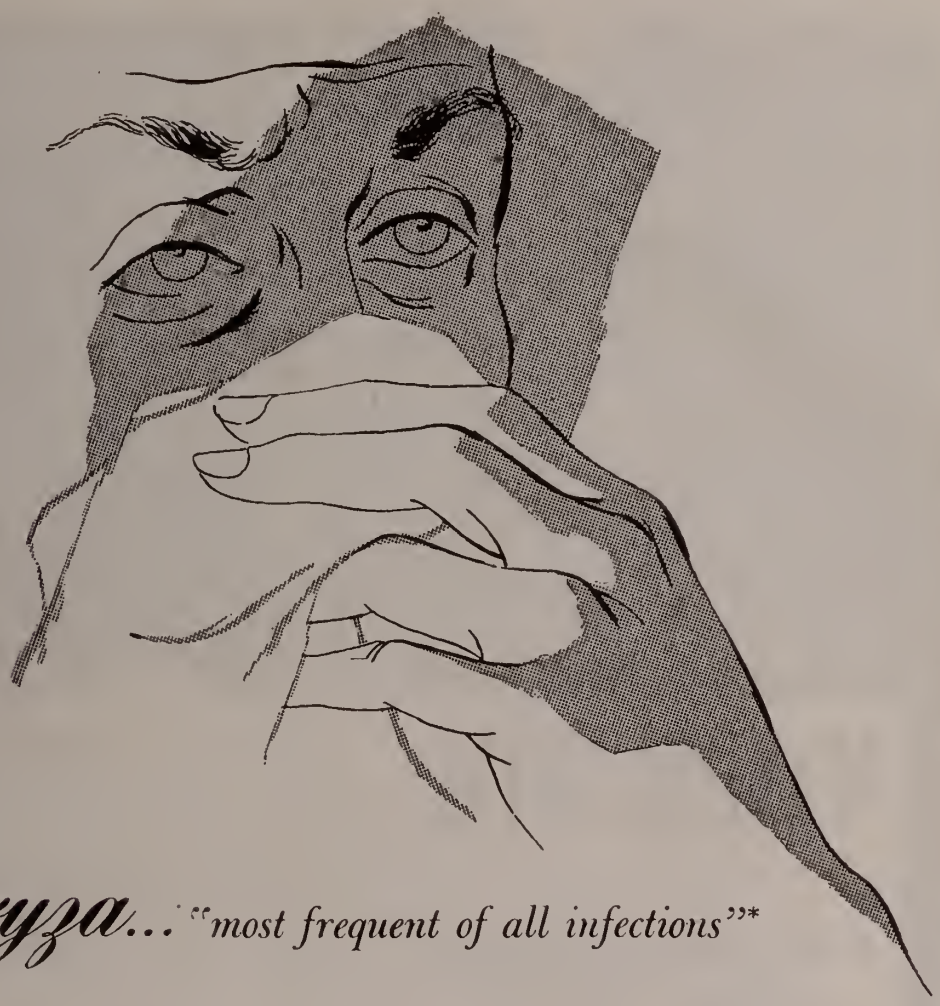
Typical of today's accelerated production lines in our Chicago plant is this lot of x-ray units, in the final stages of assembly and inspection.

It's the well-known Model R-39, resuming its characteristic role as the shockproof, all-round diagnostic unit which, because it is so compactly designed, almost invariably solves the problem of limited floor space. That's why you so often see it in the offices of specialists, in private clinics, and in many hospitals.

Here's the power you need (100 ma and 85 kvp) for radiographic and fluoroscopic diagnosis; a double-focus genuine Coolidge tube which serves both over and under the table; unusual flexibility for positioning the patient horizontally, angularly, or vertically; and an operator's control so refined and yet so simple to operate that you can consistently produce radiographs of the preferred diagnostic quality.

Model R-39 may well prove ideally adaptable to your specific x-ray needs at this time. Why not write for full particulars today. Ask for Publication 2567. Address General Electric X-Ray Corporation, 175 W. Jackson Blvd., Chicago 4, Ill.

**GENERAL ELECTRIC X-RAY CORPORATION**



# *Coryza...* "*most frequent of all infections*"*

While coryza is still in the field of the "great unknown", it is generally recognized that two of its problems can and should be met.

COMFORT: Symptomatic relief from engorged nasal mucosa and occluded sinus ostia can be readily obtained with the sure *but gentle* vasoconstrictor action of the 0.125% *dl*-desoxyephedrine hydrochloride contained in Squibb SULMEFRIN.

PROTECTION: Complications due to multiplication of secondary pathogens may be prevented by the antibacterial action of sodium sulfathiazole anhydrous 1.25% and sodium sulfadiazine 1.25% – active bacteriostatic agents in Squibb SULMEFRIN.

*Birkelond, J.: Microbiology and Man, Boltimore, Williams and Wilkins, 1942, p. 215.

Sulmefrin
TRADEMARK

SQUIBB

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858




# MANDELAMINE

Reg. U.S. Pat. Off.
(Methenamine Mandelate)

## IS AN ESPECIALLY EFFECTIVE URINARY ANTISEPTIC

***Safety, ease of administration, and characteristically prompt action combine to make Mandelamine an especially efficient agent in the treatment of urinary infections in children and in elderly patients.***

Freedom from drug toxicity is an important consideration to the busy physician who is unable to maintain patients under close medical supervision. Mandelamine may be confidently prescribed in therapeutic dosage virtually without consideration of toxic effects.

Uncomplicated oral administration of Mandelamine requires no supplementary acidification, restriction of fluid intake, dietary control, or other special measures. Only in those infections due to urea-splitting organisms, may accessory acidification be necessary.

Early control of common urinary infections is the characteristic response to Mandelamine therapy. Disturbing urinary symptoms are usually alleviated rapidly and, in the absence of obstruction, the urine is promptly cleared of organisms in a high percentage of cases.

Mandelamine is supplied in enteric coated tablets of 0.25 Gm. (3¾ grains) each, in packages of 120 tablets sanitaped, and in bottles of 500 and 1000.




NEPERA CHEMICAL CO. INC.
21 Gray Oaks Ave.
Yonkers 2, New York

Please send me literature, and a physician's sample of Mandelamine.

Name.....M.D.

Street.....

City.....State.....

**NEPERA CHEMICAL CO. INC.**

***Manufacturing Chemists*** Nepera Chemicals **Yonkers 2, New York**



## to combat persistent depression in the aged patient

Old age sometimes brings a severe and lasting depression, marked by self-absorption, withdrawal from former interests and loss of capacity for pleasure. This depression often aggravates underlying pathology by interfering with exercise, appetite and sleep.

Because of its power to restore mental alertness and zest for living, Benzedrine Sulfate helps to overcome depression and anhedonia in the aged. Obviously, careful observation of the aged patient is desirable; and the physician will distinguish between the casual case of low spirits and a true and prolonged mental depression. The dosage should be adjusted to the individual case.

**benzedrine sulfate**

(*racemic amphetamine sulfate, S.K.F.*) Tablets and Elixir

Smith, Kline & French Laboratories, *Philadelphia, Pa.*



WHEN NUTRIENT INTAKE IS

*of Particular Importance*

The need for an augmented intake of specific nutrients frequently arises in surgery —postoperatively, during the course of febrile complications, following blood loss, in traumatic surgery, and in the management of septic and infected lesions. Metabolically, these conditions raise the protein and B complex vitamin requirements as well as that for ascorbic acid, and increase the need for caloric energy to offset tissue wasting and loss of weight.

When metabolic needs are raised, the delicious food drink made by mixing Ovaltine with milk fills a special need. This dietary supplement provides the specific nutrients needed in abundant quantities. Patients enjoy its delightful taste, and drink the recommended three glassfuls daily with relish. The table of composition amply illustrates the contribution it makes. Of particular importance is its low curd tension, which allows rapid gastric emptying and no interference with the appetite.

**THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.**




*Ovaltine*

Three servings daily of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk,* provide:

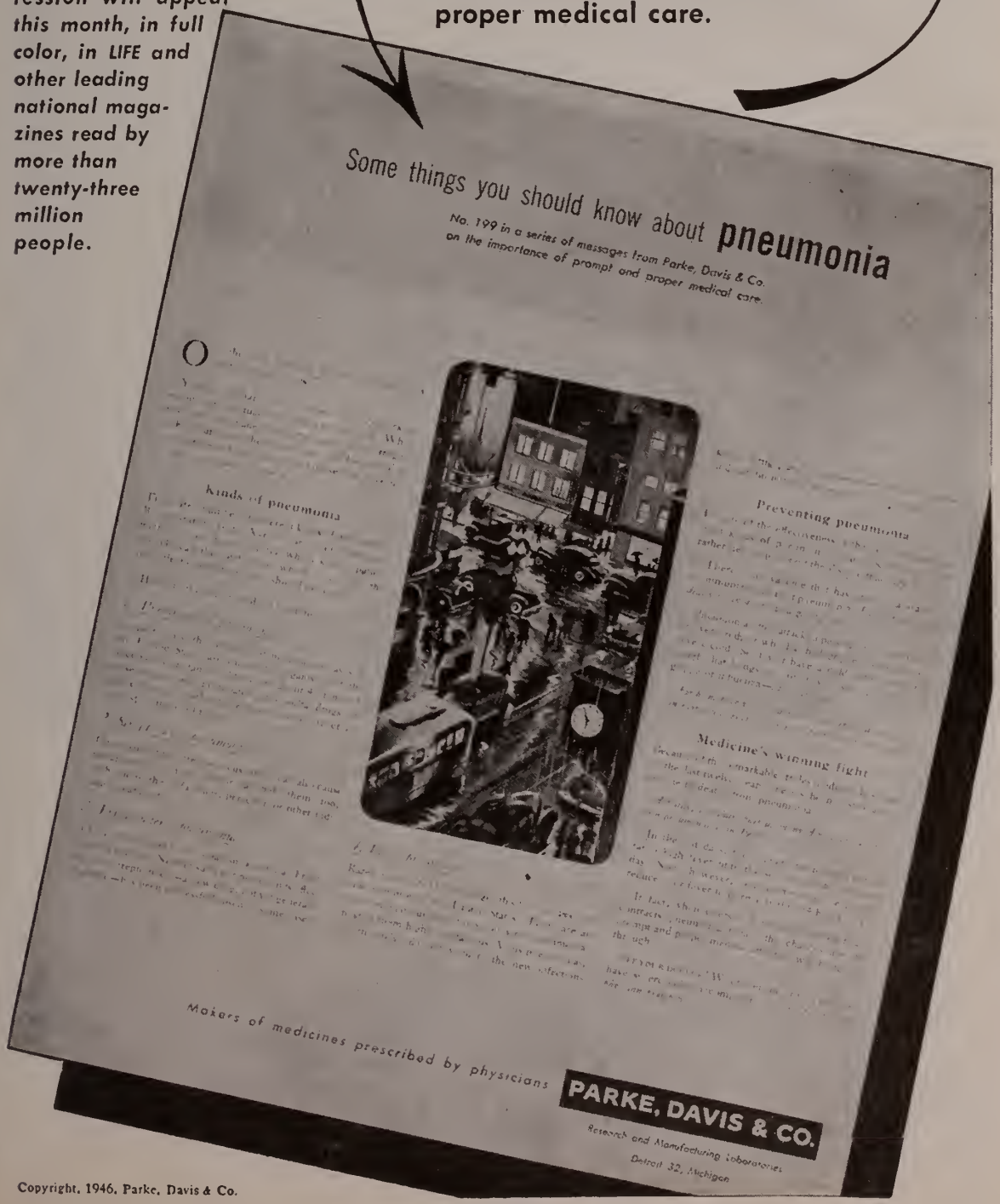
| | | | |
|---|---|---|---|
| CALORIES | 669 | VITAMIN A | 3000 I.U. |
| PROTEIN | 32.1 Gm. | VITAMIN $B_1$ | 1.16 mg. |
| FAT | 31.5 Gm. | RIBOFLAVIN | 2.00 mg. |
| CARBOHYDRATE | 64.8 Gm. | NIACIN | 6.81 mg. |
| CALCIUM | 1.12 Gm. | VITAMIN C | 39.6 mg. |
| PHOSPHORUS | 0.939 Gm. | VITAMIN D | 417 I.U. |
| IRON | 12.0 mg. | COPPER | 0.50 mg. |

*Based on average reported values for milk.

# "See Your Doctor"

**This is the 199th advertisement in the Parke-Davis series on the importance of prompt and proper medical care.**

*This timely message in behalf of the medical profession will appear this month, in full color, in LIFE and other leading national magazines read by more than twenty-three million people.*




Copyright, 1946, Parke, Davis & Co.

# P. R. N.

The Jocular Jingles of C. G. F.
by
Charles G. Farnum M. D.
Peoria, Ill.

## PATHOLOGICAL SONNETS

### Herpes Zoster

A round of golf in bleak autumnal rain,
A chilling of my body to the core,
In two more days a sharp thoracic pain
Intensified each day more and more.

It seemed some fiend had thrust a red hot knife
Within a space upon my tortured chest,
A fortnight gave me pain enough for life
With scarce a night of sleep or painless rest.

To merely breathe increased the burning pain,
Each therapeutic measure was a flop,
The countless pills I took were all in vain,
I hope that time will bring it to a stop.

When vicious pain with burning intermingles
Why is it everybody laughs at shingles?

### The Senior Golfer's Lament.

**In late November's chilling days**
**The sun provides no warming rays**
**On every tee I say farewell and groan;**
**The fairways gave no ray of hope,**
**In sandtraps deep I grieve and mope,**
**On every green I shed some tears and moan.**

**My days henceforth will be forlorn,**
**At night I'll sadly grieve and mourn,**
**My soul is filled with sadness, life is drear;**
**I fairly ooze and drip with grief,**
**No cheery thought can bring relief,**
**In this my final game of golf this year.**

### COMPENSATION

Once again 'tis bleak November,
As we all of us remember;
It is raining,
All pertaining
To this season of the year.

Vegetation's dead or dying
And the wind through trees is sighing,
There's some snowing
And much blowing,
And the world is sad and drear.

So we look for compensation
For this awful desolation,
That brings sadness,
And half madness,
And has cast the world in gloom.

And right merrily we snigger,
For each fly and bug and chigger
That harassed us,
Now has passed us,
And is frozen to his doom.

### AGE.

**Our young manhood seeks love and craves conflict**
**And it asks for life rugged and fast.**
**His emotions preemptory edict,**
**With scant thought of the future or past.**

**While in middle life man longs for riches**
**And positions of highest degree,**
**Lust for power and wealth so bewitches**
**Often these become all he can see.**

**But an old man wants life that is tranquil**
**And his only desire is for peace,**
**All activities then are at a standstill**
**Waiting death that will bring his release.**

**You can't guess a man's age nor come near it**
**Merely counting longevity's toll,**
**For a man is as old as his spirit**
**And his age is the age of his soul.**

I'd hate to be sailor
And sail upon the sea,
I'd rather be Norwegian
And ski and ski and ski
And yet I would decree, sir,
To which you will agree,
That each do what he chooses,
Including you and me.

### MIDDLE AGE

**We're victimized by Fate**
**in very way;**
**Our girth's becoming greater**
**every day;**
**Our vision is bi-focal,**
**Our hearing is more local,**
**The hair upon our pate**
**is getting gray.**

**Our breath is now quite short,**
**we can't go fast;**
**We care must less for sport**
**than in the past;**
**Gone is our shapely figure,**
**Our bald spot's getting bigger,**
**We're sharper with retort —**
**iconoclast.**

**Blood pressure now precludes**
**activity;**
**Three chins are arguments**
**'gainst dignity;**
**Flattened feet have lost their spring,**
**And we growl more than we sing;**
**Yet how each one resents**
**senility!**



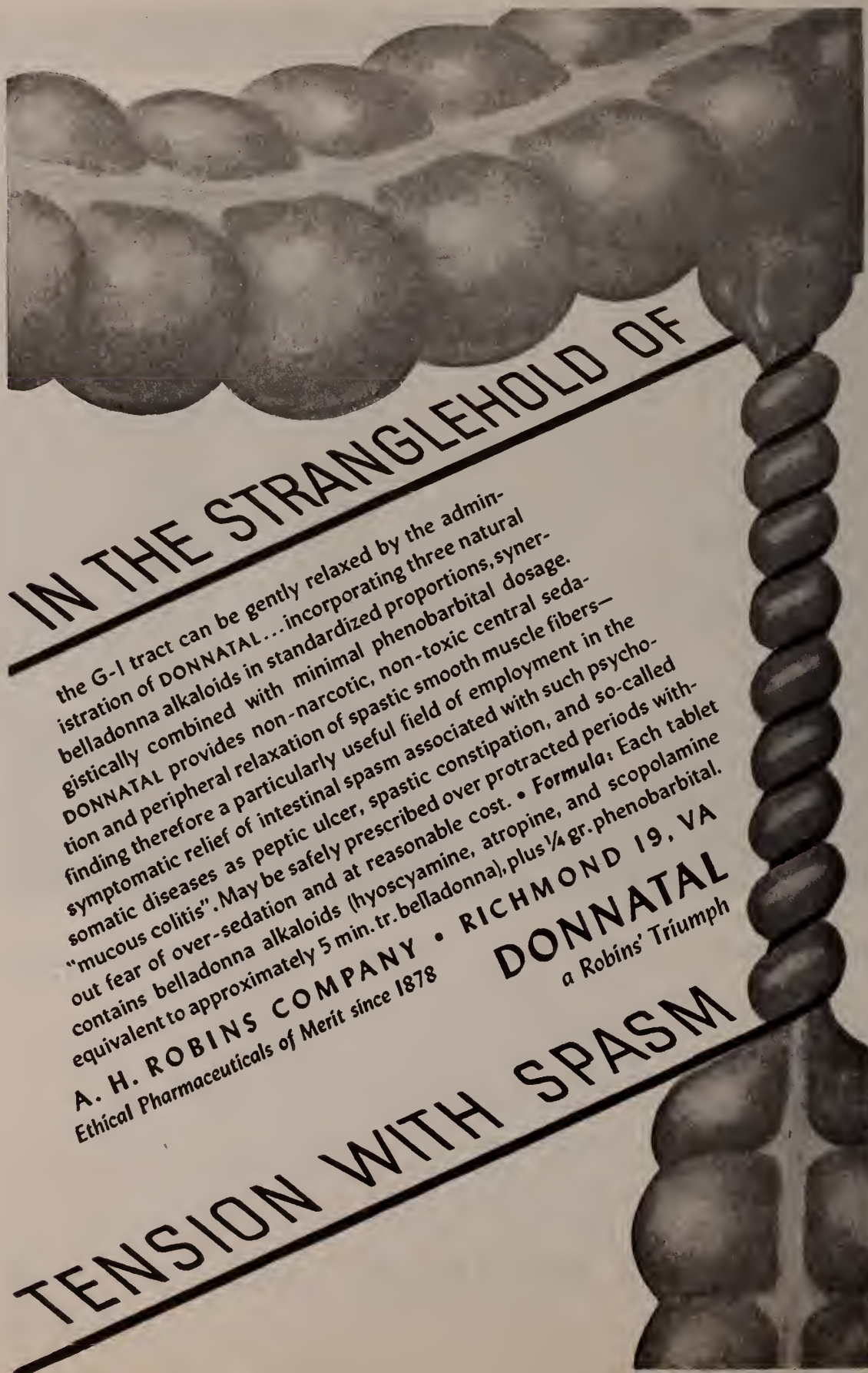

## RECOMMEND DELICIOUS KNOX DISHES MADE WITH VEGETABLES!

To paraphrase an old adage, "You can lead a child to a vegetable, but you can't make him eat!" That's why so *many* doctors recommend vegetable dishes made with Knox Gelatine. You see, Knox dresses up vitamin-rich vegetables in such a delicious fashion children will eat them right down to the last bite!

Next time a mother poses this problem, give her the new Knox Gelatine booklet "Knox Recipes Children Love." We'd be delighted to send you as many copies as you can use.
Write to Knox Gelatine, Dept. 483, Johnstown, N. Y.

**KNOX GELATINE** ALL PROTEIN, NO SUGAR




IN THE STRANGLEHOLD OF
the G-I tract can be gently relaxed by the administration of DONNATAL... incorporating three natural belladonna alkaloids in standardized proportions, synergistically combined with minimal phenobarbital dosage. DONNATAL provides non-narcotic, non-toxic central sedation and peripheral relaxation of spastic smooth muscle fibers— finding therefore a particularly useful field of employment in the symptomatic relief of intestinal spasm associated with such psychosomatic diseases as peptic ulcer, spastic constipation, and so-called "mucous colitis". May be safely prescribed over protracted periods without fear of over-sedation and at reasonable cost. • Formula: Each tablet contains belladonna alkaloids (hyoscyamine, atropine, and scopolamine equivalent to approximately 5 min. tr. belladonna), plus 1/4 gr. phenobarbital.
A. H. ROBINS COMPANY • RICHMOND 19, VA
Ethical Pharmaceuticals of Merit since 1878
DONNATAL
a Robins' Triumph
TENSION WITH SPASM

# Protein as a Therapeutic Factor In Infectious Disease

In the recent past, increasing attention has been called to the influence of severe infections upon protein metabolism and the profound destruction of tissue and serum protein which occurs in these states.[1, 2]

In many instances, prompt control of infection by sulfonamides or penicillin is not followed by the desired degree of systemic improvement. Instead, protracted, stormy convalescence supervenes. A factor which is often responsible for delayed recovery is known to be the intense protein depletion which not only accompanies but also follows in the wake of infectious disease. Not infrequently, recovery can be sharply hastened by correction of existing nutritional deficiencies, foremost among them, protein deficiency. A protein intake, adequate both qualitatively and quantitatively, thus gains increasing significance as an integral part of therapy whenever the condition under treatment is known to lead to increased nitrogen excretion.

Among the protein foods of man meat ranks high, not only because it is rich in complete, biologically adequate protein, but also because its palatability and the many attractive ways it can be prepared make it acceptable to most patients.

---

[1] Tillett, W. S., Cambier, M. J., and McCormack, J. E.: The Treatment of Lobar Pneumonia and Pneumococcal Empyema with Penicillin, Bull. New York Acad. Med. 20:142, March, 1944.

[2] Armstrong, S. H., Jr.; England, A. C., Jr.; Favour, C. B., and Scheinberg, I. H.: Anemia and Hypoproteinemia Complicating Severe Protracted Pneumonia: Treatment with Penicillin—Role of Specific Supportive Therapy in Recovery, J.A.M.A. 127:303 (Feb. 10) 1945.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.




**AMERICAN MEAT INSTITUTE**

MAIN OFFICE, CHICAGO . . . MEMBERS THROUGHOUT THE UNITED STATES

# demonstrably superior



White's

White

LABORATORIES, INC., Pharmaceutical Manufacturers, Newark 7, N. J.

# nolybdenized iron for hypochromic anemias

**Unremitting search for improved techniques has transformed transfusion from a crude, dangerous experiment to a scientific procedure. In the medicinal treatment of hypochromic anemias, a marked advance has also been achieved . . .**

Clinical evidence demonstrates the therapeutic superiority of molybdenized ferrous sulfate (Mol-Iron) over equivalent dosages of ferrous sulfate alone:

**MORE RAPID . . .** Normal hemoglobin values are restored more rapidly, increases in the rate of hemoglobin formation being as great as 100% or more in patients studied.

**MORE COMPLETE . . .** Iron utilization is similarly more complete.

**BETTER TOLERATED . . .** Gastrointestinal tolerance is excellent—even among patients who have previously shown marked gastrointestinal reactions following oral administration of other iron preparations.*

White's Mol-Iron is a *specially processed,* co-precipitated complex of molybdenum oxide 3 mg. (1/20 gr.) and ferrous sulfate 195 mg. (3 gr.).

In bottles of 100 and 1000 tablets.

*Healy, J. C.: Hypochromic Anemia, Treatment with Molybdenum-Iron Complex, Journal-Lancet *66*:218 (July) 1946.




# Mol-iron *Tablets*

NEW...
NATURAL VITAMIN D
HIGHER POTENCIES, IMPROVED FORMULA

# VI-SYNERAL VITAMIN DROPS

Now providing natural vitamin D from rich fish liver sources, and increased potencies of vitamins A and C... with pyridoxine and pantothenic acid added... Vi-Syneral Vitamin Drops is unexcelled as a multivitamin supplement for the infant's diet. NO INCREASE IN PRICE.

**more than vitamins A and D alone**

Each 0.6 cc. provides:

| | |
|---|---|
| Vitamin A* | 5000 U.S.P. Units |
| Vitamin D* | 1000 U.S.P. Units |
| Ascorbic Acid (C) | 50 mg. |
| Thiamine ($B_1$) | 1 mg. |
| Riboflavin ($B_2$) | 0.4 mg. |
| Pyridoxine ($B_6$) | 0.1 mg. |
| Niacinamide | 5 mg. |
| Pantothenic Acid | 2 mg. |

*Natural vitamins A and D

CONTAINS NO ALCOHOL

In 15 cc. and 45 cc. packages with dosage marked dropper.

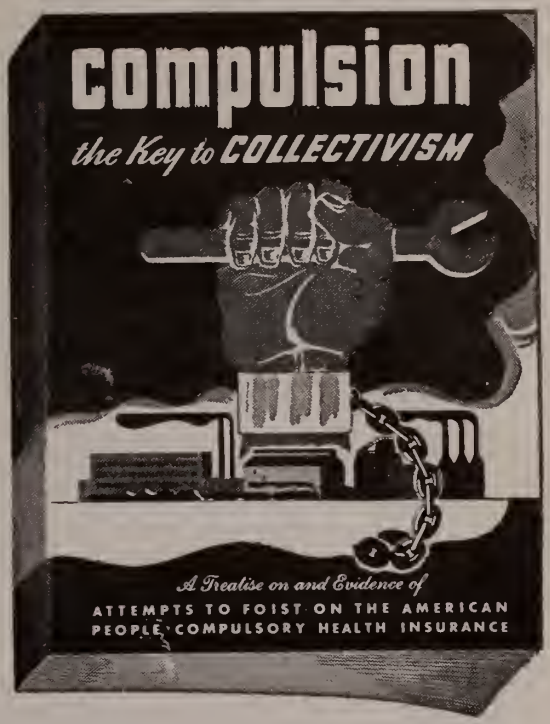
NEW IMPROVED FORMULA




Write for sample and literature

U. S. VITAMIN CORPORATION
250 East 43rd Street • New York 17, N. Y.

# THIS BOOK SENT FREE ON REQUEST TO ANY PHYSICIAN




This is the dramatic record of the recent public hearings before the Senate Committee on Education and Labor—on S.1606—which, if enacted, would impose Compulsory Health Insurance and the political distribution of medical care on the American people.

This 196-page book is published in two sections—in Section A is found in narrative form the historical background of the Political Medicine movement in the United States and throughout the world, the almost unbelievable story of the tactics of the sponsors and proponents and the stimulating and inspiring record of the opponents who fought valiantly and successfully in defense of the independence of the professions and freedom of choice for the people, under the following Chapter Titles:

• The Wagner-Murray-Dingell Bills • Historical Background of the Wagner-Murray-Dingell Bills • The Bureaucratic Propaganda Front • Government Propaganda for Political Medicine • The Mis-Used Draft Rejection Statistics • Organized Medicine's Efforts for Better Medical Care • The Why of Physician Opposition • Probing for Facts • An Elder Statesman Testifies • Compulsion the Key to Collectivism • Personnel of Senate Committee on Education and Labor.

In Section B is published more than 120 pages of actual testimony that provides the evidence of the scheming, planning and collusion outlined in the narrative.

**A copy will be sent free to any physician or any dentist on request.**

---

**National Physicians Committee**
**75 East Wacker Drive**
**Chicago 1, Illinois**

**GENTLEMEN: Please send me a copy of the 196 page book**

**"COMPULSION—THE KEY TO COLLECTIVISM." I will review this work and discuss it with friends and acquaintances. I understand I will receive this book without cost or obligation.**

**NAME** .....

**ADDRESS** .....

**CITY AND STATE** .....

# Physical Medicine Abstracts

John S. Coulter, M.D.

## PRESENT-DAY CONCEPTS OF FRACTURE MANAGEMENT

Donald C. Conzett, M.D., Dubuque

In JOURNAL OF THE IOWA STATE MEDICAL SOCIETY 36;7;282
July 1946

There are many types of treatment available following removal of the maintaining apparatus. all coming under the general classification of physicial therapy. This is a specialty of itself but every physician doing fracture work must have some knowledge of its use, and misuse. Massage has its place, but it is actually a lazy person's means of exercise and usually some form of active motion is to be prefered. Heat is of great benefit for it is analgesic and a circulatory stimulant. Whether heat is administered by infra-red, diathermy, whirlpool bath or moist applications, it should always be used to hasten return of function. The use of weights and pulleys has not had the usage that its value deserves. By the construction at home of simple devices which the patient can use, he may improve movement much more rapidly than awaiting his daily or semi-weekly visit to the doctor's office for a quick treatment and then spend the interim in idleness.

A valuable piece of apparatus for the physician to have in his office, and quite economical, is a goniometer to measure range of motion in joints. It is difficult for one to remember what degree of motion was present the last time the patient was seen. With such an instrument the doctor can measure and record the progressive improvement in the patient's condition. Its psyshic affect it likewise worthwhile, because frequently a patient becomes discouraged at the lack of speed of recovery and he will watch with interest the progress made. We keep a scale on the wall in the examining room for use of patients who are restoring shoulder motion. The gain of an inch or two in reaching upward often sends a patient home knowing that his improvement is progressing. There are many other simple aids which tend to restore the mental as well as the physicial well-being.

The present-day concept of fracture management, then, is that because of a fracture an individual has been deprived of every day activity; that this fracture must be accurately reduced by a method which will not jeopardize his complete recovery but will produce normal function with a minimum of pain and discomfort, allow early ambulation, and insure mental ease; and that, finally, he will be given all aids possible in the restoration of function to the injured member and complete rehabilitation to his former manner of living.

## PHYSICAL MEDICINE IN THE TREATMENT OF CHILDREN

Clive Shields, B.M., B.Ch., Asst. Supt. Physiotherapy Dept., St. George's Hospital; Director, Physiotherapy Dept., Victoria Hospital for Children, London

In THE BRITISH JOURNAL OF PHYSICAL MEDICINE AND INDUSTRIAL HYGIENE
9;3;83
May-June, 1946

The subject of this article may be considered from two points of view: (1) the organization, equipment and staffing of a physiotherapy department in a hospital for children, (2) the disorders of children in which physiotherapy is indicated.

*Disorders of the nervous system*

Lower motor neurone lesions

(*Continued on page* 66)




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PHYSICAL MEDICINE (Continued)

Diagnosis — The commonest causes of lower neurone lesions are anterior poliomyelitis, peripheral nerve injuries, birth palsies (Erb's and Klumpke's paralysis), and peripheral nerve lesions of uncertain origin, for example Bell's palsy.

A partial or complete reaction of degeneration is to be expected in all lower motor neurone lesions if electrical tests are carried out some 10-14 days after the onset of the condition. It is waste of time carrying out tests earlier as normal responses will be obtained until degenerative changes have occurred in the nerve.

There is now no doubt of the value of electrical stimulation combined with massage and active or passive movements in such cases (Seddon). The old idea however that a degenerated muscle is easily tired by more than 5 or 6 contractions is — I think correctly and none too soon — being abandoned.

Electrical testing of young children may be extremely difficult, and it is advisable to allow the child to play with the apparatus, and for one of the assistance to get the patient accustomed gradually to the admittedly uncomfortable skin sensations which galvanic stimulation produces.

*Upper motor neurone lesions*

The commonest lesions met with in children are the spastic paraplegias, Friedreich's ataxia and cerebral diplegia. Characteristically there is no alteration in the electrical reactions in these conditions, so that any form of electrical treatment is not required. General massage and relaxation exercises are indicated in the early stages, followed by re-education and a table of exercises designed to improve coordination as the condition improves.

*Respiratory disorders*

Asthma — Some account is given in an earlier contribution of the form which breathing exercises should take in cases of asthma (Shields).

*Orthopaedic conditions*

Massage, manipulation and faradic stimulation will be required after surgical procedures such as tendon transplantation and osteotomy and in the after-treatment of fractures; it should be stressed again, however, that active cooperation and effort by the patient should be invoked from the earliest moment.

*Postural deformities*

General postural deformities, including kypho-

(*Continued on page* 68)

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## PHYSICAL MEDICINE ABSTRACTS
(Continued)

lordosis and scoliosis and a combination of these conditions, will form a considerable proportion of orthopaedic cases referred for remedial exercises.

*Rickets*

A general ultra-violet irradiation is of the greatest value; second degree erythema doses twice weekly for long periods are required.

*Skin conditions*

A number of different skin conditions are referred to the physiotherapy department for treatment, among the commoner of which are the following.

Eczema
Alopoecia
Impetigo
Naevi

*Miscellaneous conditions*

Healing wounds

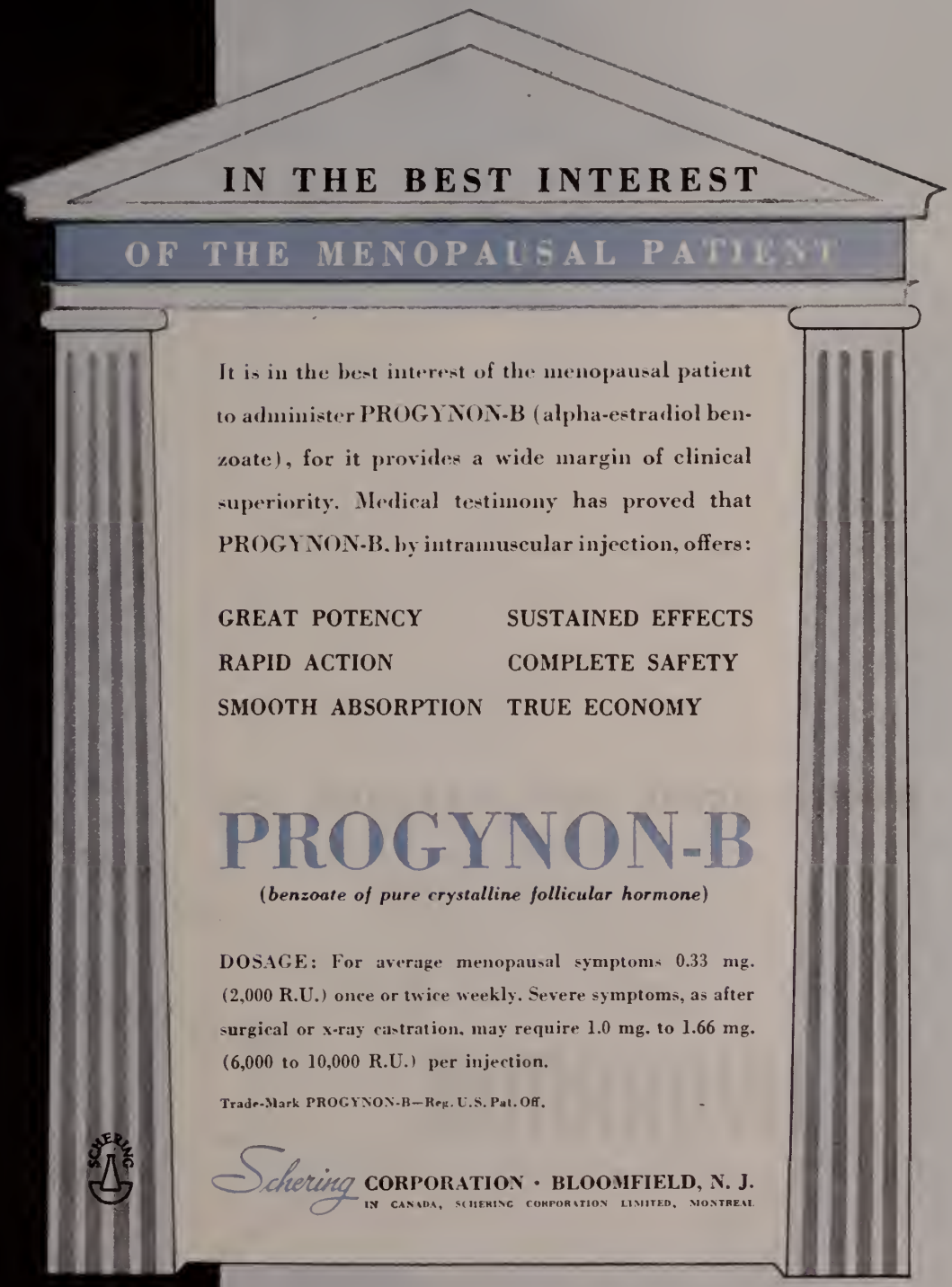
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## TRAUMATIC RUPTURE OF ADDUCTOR MUSCLES OF THIGH

G. Crile Jr.
In UNITED STATES NAVAL MED. BULLETIN, 46;719
May 1946
Abstracted in
JOURNAL OF
THE AMERICAN MEDICAL ASSN., 131;13;1098
July 27, 1946

Crile says that in the past year 3 so-called hernias of the adductor muscles of the thigh have been seen at the U. S. Naval Hospital, San Diego. A muscle hernia retracts when the muscle is tensed and bulges when the muscle is relaxed. But in the so-called adductor muscle hernia the opposite is true. The bulge is not obvious when the muscle is relaxed and appears only when the adductor muscles of the thigh are tensed. The so-called adductor muscle hernia is not a hernia at all but is a ruptured muscle. Trauma causes a rupture of the belly of one or more of the muscles of the adductor group. The ends of these muscles retract. The upper end of the muscle retains its innervation and continues to function, but it is torn loose from its insertion and it therefore contracts into a thick mass on the upper inner aspect of the thigh. This mass disappears when the muscle is relaxed and re-

(*Continued on page* 70)



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PHYSICAL MEDICINE (Continued)

appears when it is contracted. Pain and weakness of the affected thigh are common complaints. Correction of this deformity cannot be accomplished by repair of a supposed defect in the fascia. In early cases it is possible that good results could be obtained by repair of the ruptured muscle, but in late cases atrophy, contraction and fibrosis make it impossible to effect a satisfactory repair. Conservative treatment and reassurance are recommended for patients with ruptured adductor muscles. If the presence of the mass is of cosmetic importance it can be excised, but the symptoms may not be relieved.

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## PROGRESS IN CEREBRAL PALSY

Eric Denhoff, M.D.

In RHODE ISLAND MEDICAL JOURNAL
29;7;505
July 1946

*Summary*

1. Cerebral Palsy is a syndrome in which neuromuscular dysfunction is the outstanding symptom. Specific symptoms may be spasticity, athetosis, ataxia, rigidity and tremors, singly or in combination.

2. The diagnostic clinic depends on physicians with intimate knowledge of developmental behavior mechanisms, as well as consultants neurologists, orthopedic surgeons and psychologists. Newer aids to diagnosis include psychometric tests, electromyography and electroencephalography.

3. Functional self-sufficiency is the aim of any re-educational program. Physical therapy, utilizing relaxation, is the basis of good treatment.

4. Curare and neostigmine, as adjuncts to psysiotherapy promise to be of value in cerebral palsy.

---

## HEBERDEN'S NODES
## THEIR RELATION TO OTHER DEGENERATIVE JOINT DISEASES

Robert M. Stecher, M.D., Cleveland

In ARCHIVES OF PHYSICAL MEDICINE
27;7;409
July 1946

Herberden's nodes are manifestations of degenerative joint disease usually affecting the terminal and occasionally involving the proximal interphalangeal joints of the fingers. Actually, they are seen in only a small proportion of the

(*Continued on page 72*)

---

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PHYSICAL MEDICINE (Continued)

patients who seek medical advice because of degenerative joint disease.

My figures indicate that Heberden's nodes are by no means universal, even in a population of great age. In 151 men of over 70 years of age they were found in about 3 per cent and in 184 women of the same age in about 28 per cent. They are much rarer in younger women, occurring in less than 3 per cent of women under 60. They apparently occur no more frequently than this in patients with other degenerative joint disease.

The treatment of Heberden's nodes has not been satisfactory. No known therapy will make the deformities disappear once they have developed, nor has any procedure been discovered to prevent their appearance or their spread to further fingers in susceptible persons. The condition is relatively painless, but during early development the joints are inflamed and the seat of soft enlargement. Such inflamed enlargements are tender, and the fingers need protection against trauma as well as against cold. Acetylsalicylic acid gives some relief. If symptoms persist and are sufficiently severe to require it, hot soaks at home several times a day or paraffin packs several times a week are indicated. This condition of tenderness and sensitiveness is temporary, lasting from a few months to a year. The patient with Heberden's nodes frequently complains of degenerative joint disease of other joints, which also require treatment with physical means.

---

To prevent errors in diagnosis, it should be a routine practice not to make a diagnosis of pneumonia, bronchitis, asthma, pleurisy, chest cold, catarrhal fever or grippe without first considering the possibility of tuberculosis. The symptoms and physical findings in these cases may be the same as those encountered in tuberculosis. To determine definitely the presence of tuberculosis an X-ray and sputum examination and occasionally a tuberculin test are requisite for all these patients. This would not be an impractical or uneconomical procedure, for the yield of active cases of tuberculosis would be considerable. I. D. Bobrowitz, M.D. and Ralph E. Dwork, M.D., N.E. Jour. Med., Jan. 11, 1946.


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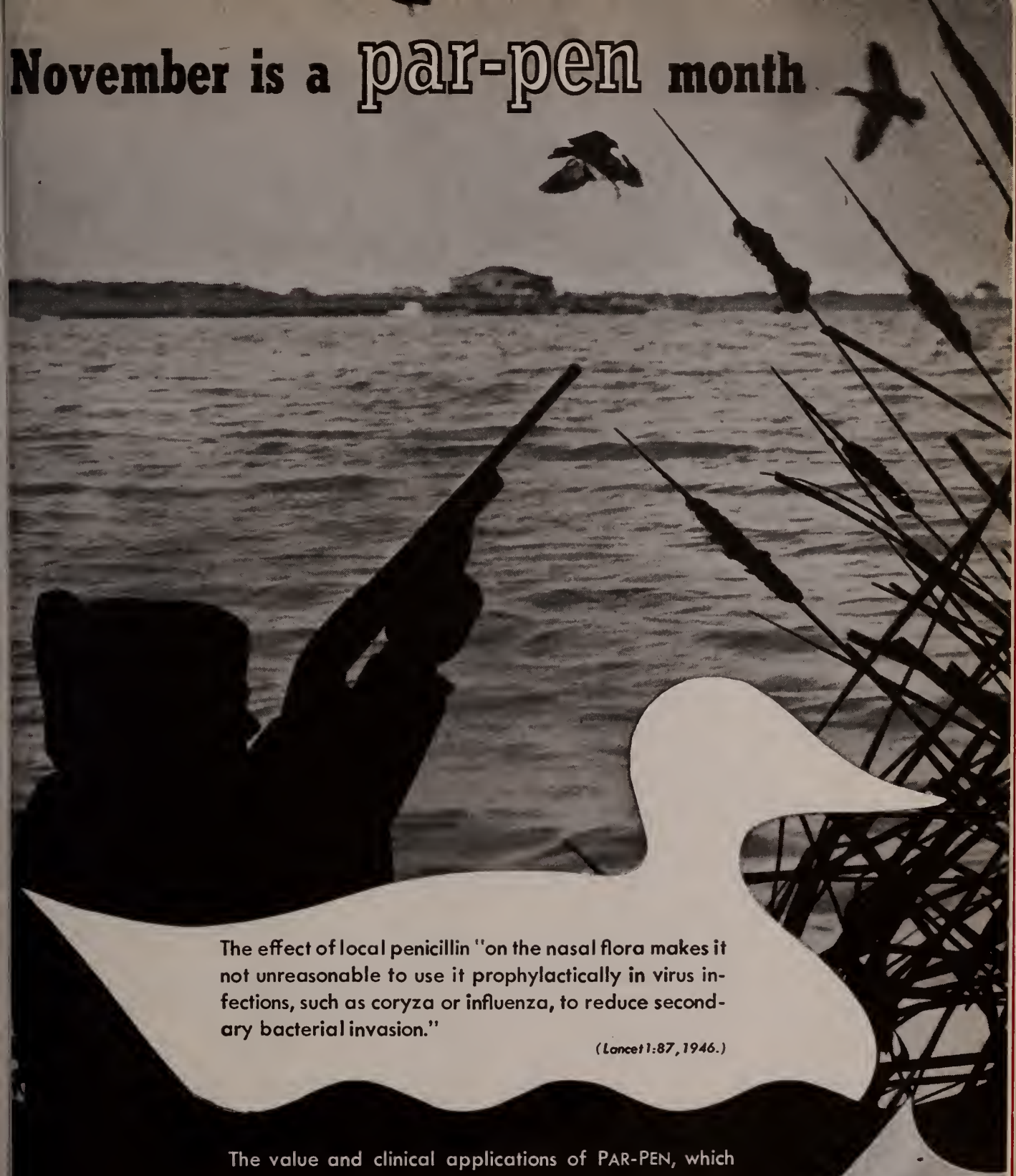
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# Book Reviews

MODERN DRUG ENCYCLOPEDIA AND THERAPEUTIC INDEX: Edited by Alexander B. Gutman, Ph.D., M.D., F.A.C.P., Third Edition. The Yorke Publishing Company, Inc., 1946.

Dr. Jacob Gutman, author of the first two editions of this book, died in May, 1944. Consequently the present author was asked to prepare the third edition which seemed in keeping with the times and with the many new drugs which have come into use during the past few years. In preparing this edition the author has consulted many pharmacologists and books, and has checked carefully the most recent information concerning the preparations under discussion.

Many new trade terms appear in the glossary giving the name and definition for the benefit of those who use the book as a quick reference when desirous of obtaining accurate information on many of the newer preparations developed for the medical profession.

The major portion of the book, quite naturally, deals with the pharmaceuticals and in addition to giving the chemical formula or composition of the many preparations, the author gives a description of the product, action and uses, administration and supply. If there are any warnings in connection with these preparations, the possibility of side reactions, development of blood dyscrasias, etc., the proper information is given in each instance.

In many cases the various companies manufacturing the preparation are listed for the convenience of the physician. The chapter on Biologicals gives in detail the generally accepted preparations of this class and much information is available for the busy practitioner which can be found readily.

The chapter on Allergens is of much interest and the field well covered, listing the generally accepted test sets available from many concerns. The thera-

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AUTHOR: MANUEL G. SPIESMAN, M.D., proctologist on staff of a number of Chicago hospitals and also former head of Cook County Hospital Rectal Clinic.

FOREWORD: ANTHONY BASSLER, M.D., FACP, consulting gastroenterologist on staff of St. Vincents and other New York City hospitals. Dr. Bassler is also President of the National Gastroenterological Association.

**Dr. Spiesman states that KALUM has been found valuable in the following disorders —with page numbers as reference:**

**CHRONIC ULCERATIVE PROCTOCOLITIS (Idiopathic)—page 163**

**ACUTE PROCTOSIGMOIDITIS—page 157**

**BACILLARY PROCTOSIGMOIDITIS—page 160**

**INTESTINAL TUBERCULOSIS—page 182**

**HYPERPLASTIC ENTEROCOLITIS—page 184**

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## BOOK REVIEWS (Continued)

peutic index consists of about 100 pages listing the preparations then the Manufacturers and Distributors index gives alphabetically the leading pharmaceutical manufacturers and their products which are mentioned in the encyclopedia.

The book is well arranged and as a quick reference should be a "must" for the average practitioner of medicine who wants to keep up to date on his knowledge concerning the selection and use of the modern drugs.

## Books Received

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

PRINCIPLES OF HEMATOLOGY: With 106 Illustrative Cases, and 167 Illustrations including 173 Original Photomicrographs and 95 Original Charts and Drawings; By Russell L. Haden, M.A., M.D., Chief of the Medical Division of the Cleveland Clinic, Cleveland, Ohio; Formerly Professor of Experimental Medicine in the University of Kansas School of Medicine, Kansas City, Kansas. Third Edition. Thoroughly Revised. Lea and Febiger, Philadelphia, 1946. Price $5.00.

THE PRINCIPLES OF NEUROLOGICAL SURGERY: By Loyal Davis, M.S., M.D., Ph.D., D.Sc., (Hon.) Professor of Surgery and Chairman of the Division of Surgery, Northwestern University Medical School, Chicago. Third Edition, Thoroughly Revised With 192 Engravings, Containing 348 Illustrations and 5 Plates, 4 in Color. Lea and Febiger, Philadelphia, 1946. Price $7.50.

PRACTICAL MALARIOLOGY: Prepared under the Auspices of the Division of Medical Sciences of the National Research Council. Paul F. Russell, M.D., M.P.H., Col. M.C., A.U.S., Parasitology Division, Army Medical School, Field Staff, Internl. Health Division, Rockefeller Foundation (on leave); Luther S. West, Ph.D., Head of Biology Department, Northern Michigan College of Education, Major, Sn.C., A.U.S. (Reserve); Formerly Entomologist, Parasitology Division, Army Medical School; Reginald D. Manwell, Sc.D., Professor of Zoology, Syracuse University, New York. Formerly Captain, Sn.C., A.U.S., Protozoology Section, Parasitology Division, Army Medical School. Foreword by Raymond B. Fosdick, President of The Rockefeller Foundation. 684 pages, 238 illustrations, 8 in color. Philadelphia & London: W. B. Saunders Company, 1946. Price $8.00.


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COMPLETE HANDBOOK ON STATE MEDICINE: By J. Weston Walch. 1946. 170 pages, 8½ x 11 inches, lithographed. Platform News Publishing Co., Box 66, Pearl Street Station, Portland, Maine. Price, $2.50 per copy.

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Tuberculosis has been a serious problem to the health authorities in every country where war means greatly lowered living standards, extreme overwork, and a governmentally regulated diet which has not yet proven adequate when rationing becomes severe. In England and Germany, two countries in which tuberculosis authorities were questioned, the war presented the ideal set of conditions optimum for the incubation and transmission of pulmonary tuberculosis. There now appears sufficient evidence to warrant the conclusion that this new type of warfare — namely the bombing of city areas for strategic purposes — compounds the problem of tuberculosis in wartime. George A. Wulp, M.D., The Effect of Bombing on Health and Medical Care in Germany, October, 1945.

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## FIVE PHYSICIANS WARN AGAINST USE OF NEW DRUG FOR EPILEPSY

State Public Should Not Be Allowed To Buy Tridione Without Prescriptions; Two Fatalities Reported

The new drug tridione, widely acclaimed for the treatment of epilepsy, has been found to carry an unpredictable toxic reaction and five physicians, writing in the September 7 issue of *The Journal of the American Medical Association*, warn that the public should not be allowed to buy the drug without a prescription.

While tridione has been tried and found effective in the treatment of hundreds of epileptic patients with no apparent ill effects, two women are known to have died as a direct result of administration of the drug. Their case histories are reported in two separate articles in *The Journal*.

One case is reported by Drs. Francis F. Harrison, Roswell D. Johnson and Darrell Ayer, of Cooperstown, N. Y., and the other by Drs. Roland P. Mackay and Werner K. Gottstein, who are from the Department of Neurology and Neurological Surgery, University of Illinois College of Medicine, Chicago.

Both patients died from a disease known as aplastic anemia. This condition often develops in persons who are poisoned with benzine or similar substances, or who have worked too long with radium or x-rays. One of the chief symptoms of the disease is deficient blood cell formation.

The Cooperstown doctors say their patient, a 16 year old girl who had suffered from convulsive seizures for three years, died following the use of tridione and hydantoin. The treatment, they say, was successful in controlling attacks, but the patient gradually began to notice difficulty in breathing, palpitation on exertion, unusual fatigue, and a throbbing sensation in her head. The patient later suffered hemorrhages. All the measures used to prevent and treat infection, stimulate blood cell production and arrest bleeding proved of no value.

The two Chicago doctors say their patient was a 23 year old unmarried woman who had suffered convulsive seizures since she was five years old. After repeated major convulsive seizures, tridione was administered. Later she suffered from severe headaches, with vomiting, generalized weakness and fatigue. Autopsy revealed extensive hemorrhages throught the body.

In discussing the case, Drs. Mackay and Gottstein say:

"There is little doubt that death was due to tridione. The only drugs used by the patient for 10 months prior to her death were phenobarbital and tridione, and she had taken phenobarbital almost constantly for 19 years without ill effect.

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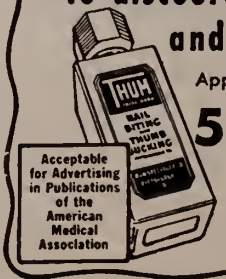
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"The destruction of the elements of her blood was delayed but abrupt. The acute onset of her illness came only after 10 months, but it came suddenly. These facts strongly suggest a progressive accumulation of the drug, or of toxic fractions of it, in the body. As late as two days before her admission to the hospital she walked several blocks without distress. The process was therefore catastrophic and apparently uninfluenced by vigorous treatment."

After outlining several suggestions to other physicians on the use of tridione, the Chicago doctors say:

"Unprescribed sale of the drug to the public should not be allowed. The present enthusiasm for tridione, both among the profession and with the public, is very great, because of the glowing accounts which have appeared in the scientific and public press, and even on the radio. The public knows the drug by name and can buy it on the market. A doctor's prescription is recommended on the company's labels and should be required.

"Finally, further research with tridione and related substances must be carried out. Despite the unfortunate toxic effects of tridione revealed in this case, the drug offers great promise for effective control of the most stubborn of all convulsive disorders, if its dangers can be avoided. The promise should be fulfilled."

Commenting editorially on the use of the drug, *The*

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## EPILEPSY (Continued)

*Journal* says:

"Until more frequent serious toxic effects are encountered with tridione, its continued use with due regard to such occurrences is considered to be a comparatively safe adjunct in the treatment of epilepsy, but these reports once again demonstrate the need for constant observation of patients when the effective, but potent, drugs of today are administered."

## TULAREMIA, RABBIT-BORNE DISEASE TRANSMITTED BY PHEASANT

Tularemia, usually caused by contact with rabbits, was acquired by a patient after eating pheasant, according to two doctors writing in the August 31 issue of *The Journal of the American Medical Association.*

N.J. Kursban, M.D., and Lee Foshay, M.D., from the Department of Medicine, the Jewish Hospital, and the Department of Bacteriology, University of Cincinnati College of Medicine, and the Cincinnati General Hospital, state that the only other known instance of transmission from the pheasant was reported in 1936.

A person suffering from tularemia develops swellings of the skin with the formation of abscesses, swelling of the lymph glands and small spots of infection in the internal organs.

The authors point out that the "predominant role of wild rabbits and hares as sources of human tularemia has focused attention so narrowly on these animals that the possibility of transmission from other sources may be overlooked."

---

The health officer should look upon tuberculosis as a communicable disease that calls for his best efforts to assist the physician in obtaining adequate treatment for the patient and the maximum protection for the public. His responsibility is the same whether the case reported is tuberculosis, diphtheria, or smallpox. (Henry D. Chadwick, M.D. and Alton S. Pope, M.D. "The Modern Attack on Tuberculosis.")

---

The veteran returning with tuberculosis places an added responsibility on the community. The incentive for many veterans to remain in their homes will constitute a menace to the public health. If we are to cope with this problem we must approach it with an understanding attitude. We must remember that although these veterans are the responsibility of the Government, they are also residents of the community, and, as such, are entitled to the same consideration as is given tuberculous non-veterans. When the tuber- presents a health problem that must be solved by that community. (William H. Hickerson, M.D. NTA Bull., Dec., 1945.)

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*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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# The ILLINOIS Medical Journal

VOL. 90 ✳ NO. 6

December, 1946

In This Issue

## The Management Of Acute Craniocerebral Trauma

✦

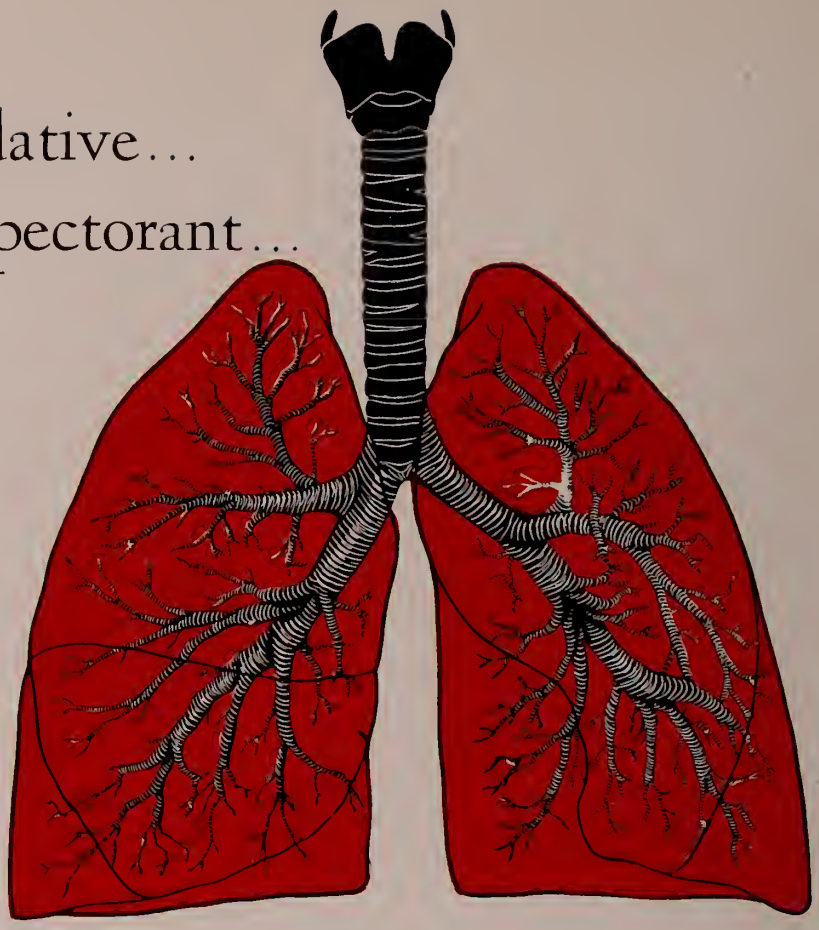
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(See page 39 for complete table of contents)

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Wier, F.A.: Clin. Med. & Surg. 43:217.

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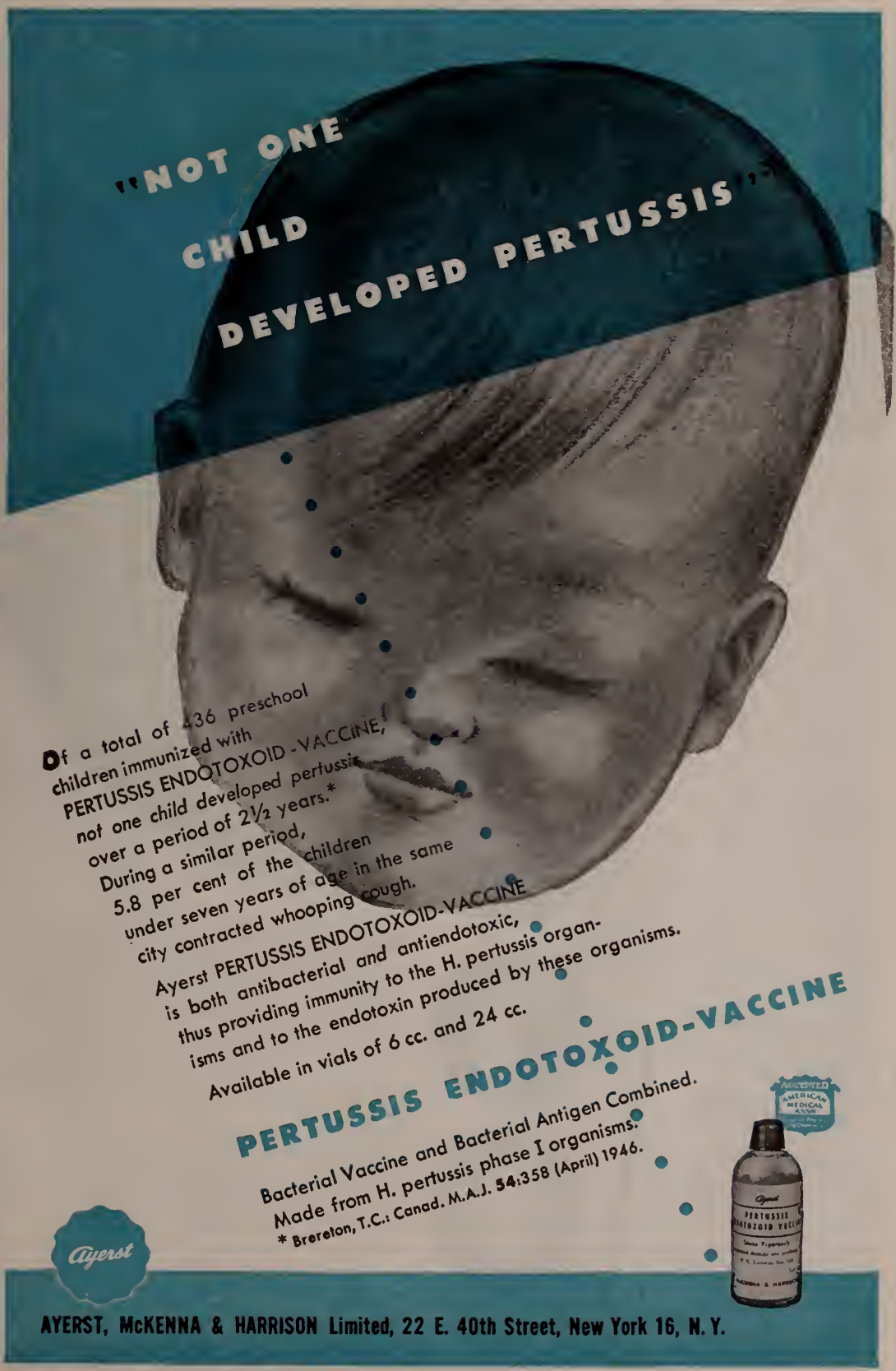
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* Brereton, T.C.: Canad. M.A.J. 54:358 (April) 1946.
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(1) Keefer, C. S.: Am. J. M. Sc. 210: 147 (Aug.) 1945.



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(2) Morse, F. W.: J. A. M. A. 132: 272 (Oct. 5) 1946; (3) Segal, M. S., and Ryder, C. M.: Bull. New England M. Center 7: 279 (Dec.) 1945.



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(4) Finland, M.; Meads, M., and Ory, E. M.: J. A. M. A. 129: 315 (Sept. 29) 1945; (5) Collen, M. F.; et al.: Permanente Found. M. Bull. 3: 155 (Oct.) 1945.

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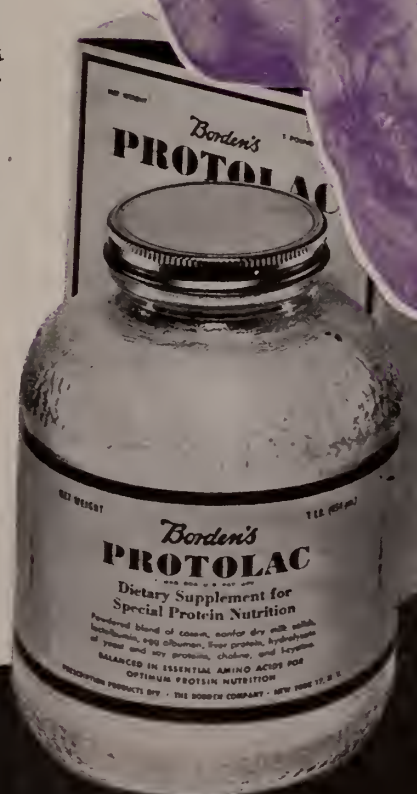
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350 Madison Avenue, New York 17, N. Y.



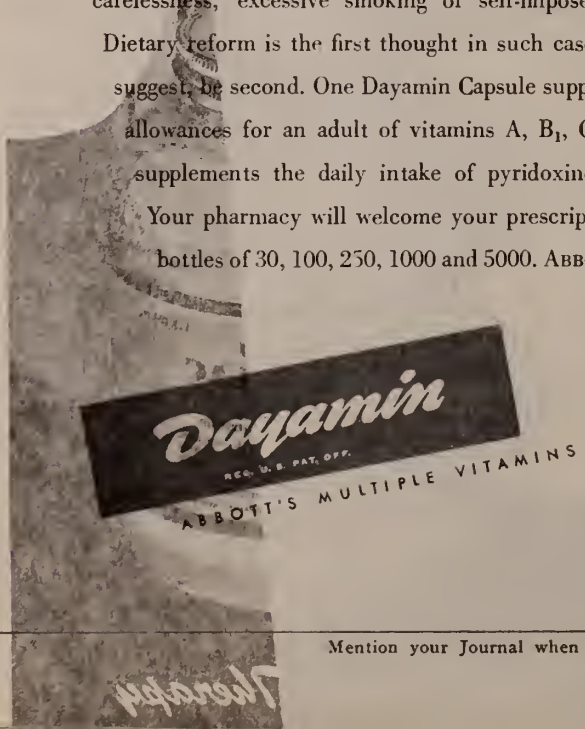

***PROTOLAC for High Protein Therapy***



## Distinguished Jurist . . .

## Dietary Dub!

His orders on the bench conform to law and evidence, but his orders at the table are influenced by hearsay, fads and violent likes and dislikes for certain foods. The result is that he, like innumerable other persons whose dietary habits are based on whims instead of nutritive values, faces the danger of subclinical vitamin deficiency. Still others in the same category are those whose eating habits are impaired by ignorance, carelessness, excessive smoking or self-imposed and ill-advised reducing diets. Dietary reform is the first thought in such cases, of course. Dayamin Capsules, we suggest, be second. One Dayamin Capsule supplies *more* than the recommended daily allowances for an adult of vitamins A, $B_1$, C, D, riboflavin and nicotinamide, and supplements the daily intake of pyridoxine hydrochloride and pantothenic acid. Your pharmacy will welcome your prescriptions. Dayamin Capsules are supplied in bottles of 30, 100, 250, 1000 and 5000. ABBOTT LABORATORIES, North Chicago, Illinois.




EACH DAYAMIN CAPSULE CONTAINS:

| | |
|---|---|
| Thiamine Hydrochloride | 5 mg. |
| Riboflavin | 5 mg. |
| Nicotinamide | 25 mg. |
| Pyridoxine Hydrochloride | 1.5 mg. |
| Pantothenate Acid (as calcium pantothenate) | 5 mg. |
| Ascorbic Acid | 100 mg. |
| Vitamin A | 10,000 U.S.P. units |
| Vitamin D | 1,000 U.S.P. units |

special formula

specific job

'Prothricin' Antibiotic Nasal Decongestant combines tyrothricin (0.02%) with 'Propadrine' hydrochloride* (1.5%) for the specific purpose of re-establishing normal drainage and combatting bacterial infection in the local treatment of sinusitis, rhinitis, coryza and nasal congestion.

Tyrothricin has a number of advantages over penicillin and the sulfonamides as a local antibiotic. The antibacterial range of tyrothricin is essentially the same as that of the sulfonamides, but tyrothricin when applied locally does not produce toxic effects, sensitize the patient, or produce a precipitate on the ciliated mucosa which may block drainage and impair normal function.

Applied locally, tyrothricin promptly attacks bacteria, and its low surface tension promotes penetration of tissue crevices and mucosal folds. Penicillin, unlike tyrothricin, is rapidly absorbed and removed from the site of application.

In addition to the antibacterial action of tyrothricin, 'Prothricin' decongestant contributes to normal drainage and re-establishment of mucosal function by means of 'Propadrine' hydrochloride, an effective vasoconstrictor notably free from the unpleasant side-effects of ephedrine and its analogs.

'Prothricin' Antibiotic Nasal Decongestant is supplied in 1-ounce, dropper-assembly bottles bearing no expiration date, for this solution is stable, and indefinitely retains full antibacterial-vasoconstrictor potency at ordinary room temperature.

Sharp & Dohme, Philadelphia 1, Pa.

*Council-Accepted

SHARP & DOHME

'PROTHRICIN'

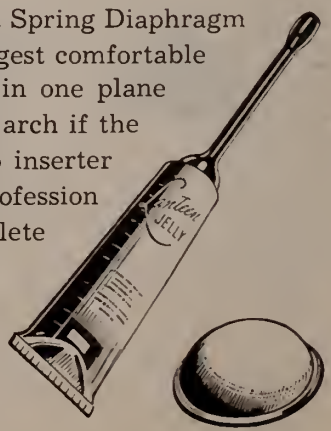
*antibiotic nasal decongestant*

# *Toward a Better World*



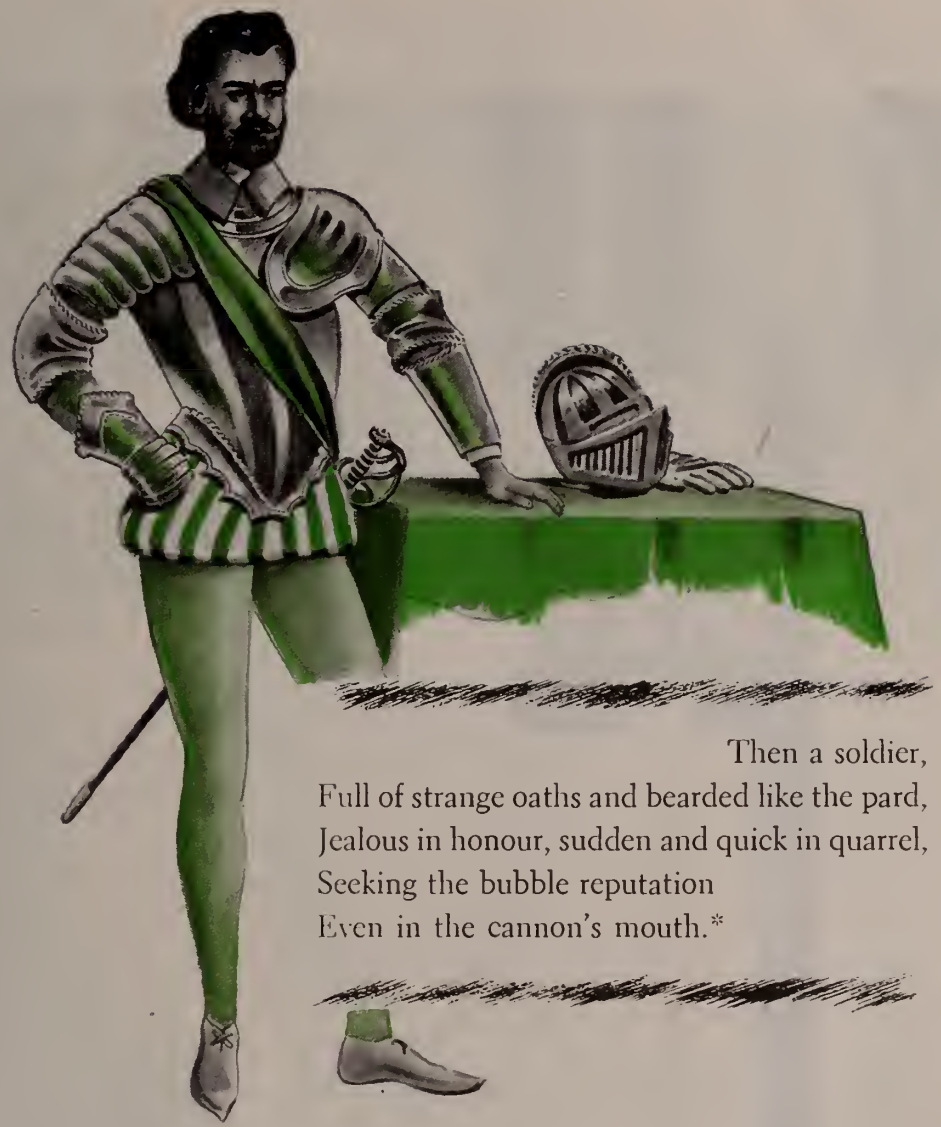

Progress also is taking place in sociological betterment . . . promotion by Lanteen Medical Laboratories of Lanteen products. These leaders in their field are produced under most rigid scientific standards.

*Instruction of patients* in the use of the Lanteen Flat Spring Diaphragm is simple, and proper placement is assured when largest comfortable size is fitted. Because the diaphragm is collapsible in one plane only, the outer rim cannot be forced into the pubic arch if the entering rim becomes lodged against the cervix. No inserter is required. Advertised exclusively to the medical profession . . . available only through ethical sources. Complete package available to physicians upon request.




**Lanteen**

LANTEEN MEDICAL LABORATORIES, INC. • CHICAGO 10



Then a soldier,
Full of strange oaths and bearded like the pard,
Jealous in honour, sudden and quick in quarrel,
Seeking the bubble reputation
Even in the cannon's mouth.*

SOLDIER or civilian, a young man's frequent dietary indiscretions and usual high-strung existence often manifest the need for re-establishment of normal bowel function.

ZymenoL** through enzymatic action inhibits excessive fermentation or putrefaction and aids restoration of normal intestinal motility with complete, natural vitamin B complex. Soft, bulky, daily defecation is assured without strain or irritation.

Absence of laxative drugs, artificial bulkage or interference with vitamin absorption commends ZymenoL to the physician.

Palatability, small, economical yet effective teaspoon dosage, and freedom from embarrassing mineral oil leakage assure excellent patient control in this often not too manageable age group.

Available in 8 and 14 oz. prescription units.

OTIS E. GLIDDEN & CO., Inc., Evanston, Ill.

**ZymenoL, an entire aqueous culture of brewers' yeast in emulsion, assures natural enzymes and complete natural vitamin B complex without live yeast cells. Sugar free.

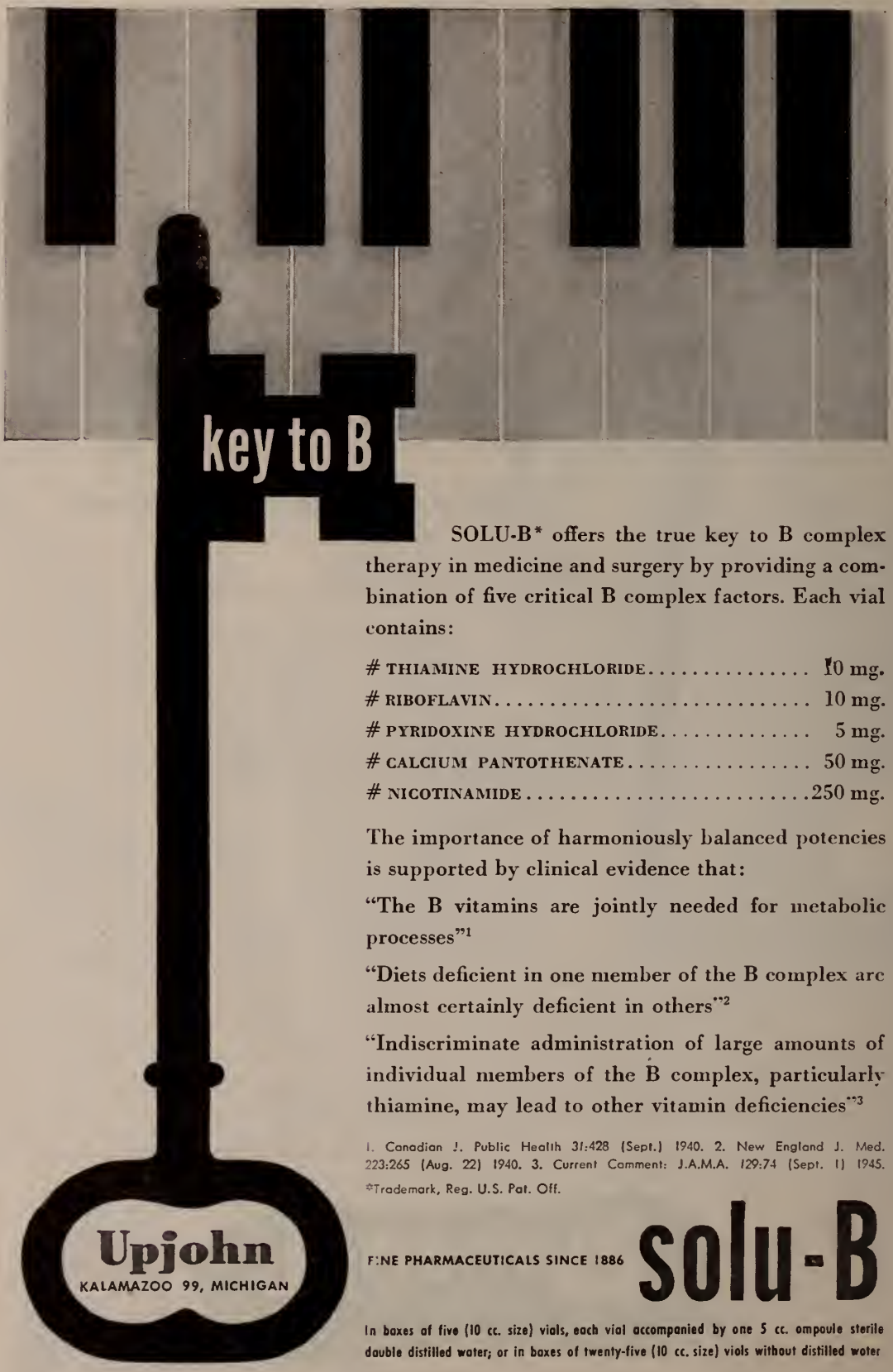
**ZymenoL**

**Brewers' Yeast in Emulsion**




**FOR EFFECTIVE BOWEL MANAGEMENT**

*Fourth of a series depicting the Seven Ages of Man. From Shakespeare's "As You Like It."




SOLU-B* offers the true key to B complex therapy in medicine and surgery by providing a combination of five critical B complex factors. Each vial contains:

| | |
|---|---|
| # THIAMINE HYDROCHLORIDE | 10 mg. |
| # RIBOFLAVIN | 10 mg. |
| # PYRIDOXINE HYDROCHLORIDE | 5 mg. |
| # CALCIUM PANTOTHENATE | 50 mg. |
| # NICOTINAMIDE | 250 mg. |

The importance of harmoniously balanced potencies is supported by clinical evidence that:

"The B vitamins are jointly needed for metabolic processes"[1]

"Diets deficient in one member of the B complex are almost certainly deficient in others"[2]

"Indiscriminate administration of large amounts of individual members of the B complex, particularly thiamine, may lead to other vitamin deficiencies"[3]

1. Canadian J. Public Health 31:428 (Sept.) 1940. 2. New England J. Med. 223:265 (Aug. 22) 1940. 3. Current Comment: J.A.M.A. 129:74 (Sept. 1) 1945.

*Trademark, Reg. U.S. Pat. Off.

FINE PHARMACEUTICALS SINCE 1886 **solu-B**

In boxes of five (10 cc. size) vials, each vial accompanied by one 5 cc. ampoule sterile double distilled water; or in boxes of twenty-five (10 cc. size) vials without distilled water




# *days and days of dysmenorrhea*

The days lost because of dysmenorrhea mount up and can never be regained. Therefore, when a woman's calendar regularly prophesies inevitable painful menses, physiologic readjustment of the endocrine system is in order. This may be attained with PRANONE in the majority of patients whose dysmenorrhea is due to hormonal imbalance.[1] Premenstrual tension states, also of endocrine origin, are similarly benefited by PRANONE.

# PRANONE *tablets*

PRANONE (anhydrohydroxy-progesterone) Tablets, exhibiting corpus luteum-like activity when administered orally, are available in 5 mg. and 10 mg. strengths; in boxes of 20, 40, 100 and 250 tablets.

[1]Harding, F. E.: Am. J. Obst. & Gynec. **50**:56, 1945.
Trade-Mark PRANONE—Reg. U.S. Pat. Off.

SCHERING

*Schering* CORPORATION · BLOOMFIELD, NEW JERSEY
IN CANADA, SCHERING CORPORATION LIMITED, MONTREAL

# *The only vasoconstrictor-sulfonamide which contains Micraform*

Micraform sulfathiazole crystals are extremely minute—approximately 1/1000 the mass of ordinary crystals.

Because Paredrine-Sulfathiazole Suspension contains these minute Micraform crystals, it does not cake or clump, and does not inhibit normal ciliary action. (See the clinical drawings on the opposite page.)

Moreover, when ciliary action is impaired by infection, the Suspension's Micraform sulfathiazole spreads in a fine, even film over the affected mucosa, where it establishes bacteriostasis which often lasts for hours.

*Rhinitis . . . Sinusitis . . . Nasopharyngitis . . . Pharyngitis*

## *Paredrine-Sulfathiazole Suspension*

*Vasoconstriction in minutes . . . Bacteriostasis for hours*

*No ciliary inhibition . . .*

*No caking . . . No clumping*

# *sulfathiazole*



● Five minutes after instillation of Paredrine-Sulfathiazole Suspension in a convalescent nose, the cilia are already forming streams of Micraform sulfathiazole.

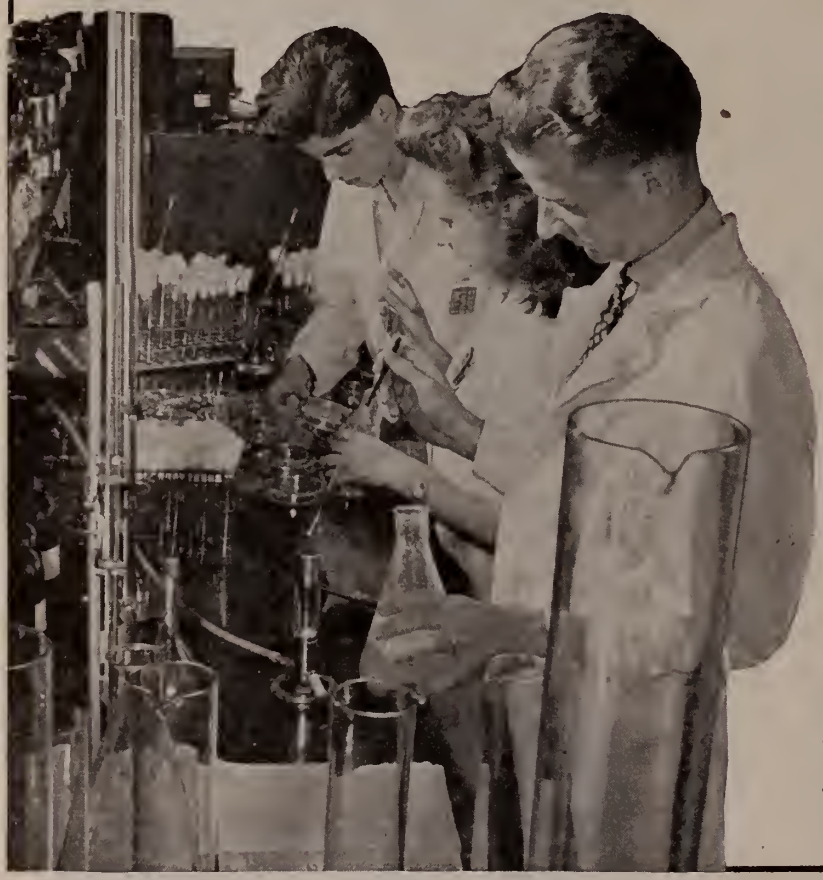


● 35 minutes later, the cilia have swept almost all the sulfathiazole away. There is no caking or clumping on *ciliated* epithelium. A few crystals, dried by inspired air, still adhere to the *non-ciliated* anterior borders of the turbinates and to the vibrissae.

***Smith, Kline & French Laboratories***

*Philadelphia, Pa.*

# PURE VITAMINS
## —Products of Merck Research



Thiamine Hydrochloride U.S.P.
(Vitamin $B_1$ Hydrochloride)

Riboflavin U.S.P.
(Vitamin $B_2$)

Niacin
(Nicotinic Acid U.S.P.)

Niacinamide
(Nicotinamide U.S.P.)

Pyridoxine Hydrochloride
(Vitamin $B_6$ Hydrochloride)

Calcium Pantothenate
Dextrorotatory

Ascorbic Acid U.S.P.
(Vitamin C)

Vitamin $K_1$
(2-Methyl-3-Phytyl-1,4-Naphthoquinone)

Menadione U.S.P.
(2-Methyl-1,4-Naphthoquinone)
(Vitamin K Active)

Alpha-Tocopherol
(Vitamin E)

Alpha-Tocopherol Acetate

Biotin

*Merck & Co., Inc. now manufactures all the vitamins commercially available in pure form, with the exception of vitamins A and D.*

Merck research has been directly responsible for many important contributions to the synthesis, development, and large-scale production of individual vitamin factors in pure form.

In a number of instances, the pure vitamins may be considered to be products of Merck research. Several were originally synthesized in The Merck Research Laboratories, and others have been synthesized by Merck chemists and collaborators in associated laboratories.

Because most of the known vitamins have now been made available in pure form, effective therapy of specific vitamin deficiencies can be conducted on a rational and controlled basis, under the direction of the physician.

# MERCK VITAMINS

MERCK & CO., Inc. RAHWAY, NEW JERSEY

*Manufacturing Chemists*

MERCK MERCK



## PITMAN-MOORE

# Influenza Virus Vaccine, Types A and B

### Refined and Concentrated

(Bio. 350)

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

PREPARED from Influenza Virus, Types A and B, propagated in the extraembryonic fluids of the developing chick embryo, concentrated, refined by the red cell elution method, inactivated, and preserved with sodium ethyl mercuri thiosalicylate.

Influenza virus vaccine is one of the outstanding medical contributions of World War II. Likewise, its production in tremendous quantities was one of the war-time contributions of the Pitman-Moore Laboratories.

Following the preliminary investigation of Influenza Virus Vaccine by the Army's Commission on Influenza early in the war, Pitman-Moore Company was one of the first to deliver this vaccine to the armed forces. During and following the war, our laboratories produced hundreds of thousands of doses for military use.

Coincident with the release of the product for civilian use, our laboratories made the first public announcement of its availability to the civilian medical profession.

*Supplied in 1 and 5-dose packages*



*Above: Harvesting the virus-laden extraembryonic fluids from partially incubated eggs, impregnated with influenza virus.*

*Left: Injecting influenza virus into eggs. During incubation the virus multiplies in the extraembryonic fluids.*

PITMAN-MOORE COMPANY

PHARMACEUTICAL AND BIOLOGICAL CHEMISTS

Division of Allied Laboratories, Inc. · Indianapolis 6, Indiana

# Digitoxin of Choice

## When Congestive Failure Supervenes




DIGITALINE NATIVELLE—the chief active glycoside of Digitalis purpurea—merits first consideration when congestive heart failure, auricular fibrillation, or auricular flutter must be combatted. The original digitoxin, it is 95% pure, the most highly purified digitoxin available. Digitaline Nativelle is the digitoxin employed in the bulk of the modern studies on this remarkable drug. Note the advantageous features which characterize the clinical behavior of this outstanding carditonic agent:

"....possesses properties which place it first in the choice of digitalis materials for general therapeutic use."[1]

Potency always uniform. Dosage calculated in terms of weight of drug.

Completely and readily absorbed by the gastrointestinal tract.[2]

Produces the same results, with virtually the same speed, by mouth as by vein.

Virtually free from nausea and vomiting due to local irritation.[3]

Digitalizes in 6 to 10 hours on *oral* administration of 1.2 mg.[1,4]

Maintenance dose, 1 tablet daily of 0.1 mg.

Physicians are invited to send for samples, literature, and a copy of the brochure "Management of the Failing Heart."

### How Supplied

Digitaline Nativelle is available through all pharmacies in 0.1 mg. tablets (pink) and 0.2 mg. tablets (white) in bottles of 40 and 250, and in ampules of 0.2 mg. (1 cc.) and 0.4 mg. (2 cc.) in packages of 6 ampules and 50 ampules.

• •

1. Gold, H.: Connecticut M. J. 9:3 (Mar.) 1945.
2. Levine, Samuel A.: Clinical Heart Disease, ed. 3, Philadelphia, W. B. Saunders Company, 1945, p. 273.
3. Gold, H.; Kwit, N. T.; Cattell, M., and Travell, J.: J.A.M.A. *119*-928 (July 18) 1942.
4. Gold, H.; Cattell, M.; Modell, W.; Kwit, N. T.; Kramer, M. L., and Zahm, W.: J. Pharmacol. & Exper. Therap. *82*:187 (Oct.) 1944.

ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

**VARICK PHARMACAL COMPANY, INC.**

*A Division of E. Fougera & Co., Inc.*

**75 Varick Street, New York 13, N. Y.**

Digitaline Nativelle

REG. U. S. PAT. OFF.

**THE ORIGINAL DIGITOXIN**

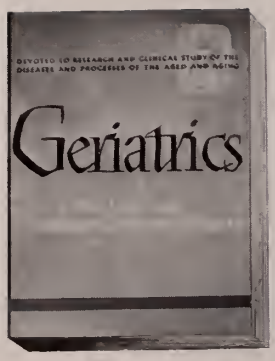


# Every day more gynecologic conditions call for Ciba steroid hormones

In an ever-increasing number of female patients, the greatest aid to recovery and normal maintenance lies in hormone therapy. To the long-accepted indications . . . dysmenorrhea, the menopause, primary and secondary amenorrhea, threatened or habitual abortion . . . are being added many common conditions not formerly thought amenable to endocrine therapy. In the important field of the estrogens, Ciba offers the chemically pure and esterified derivatives of α-estradiol, the natural estrogen. Not being metabolic breakdown products, these substances provide highest potency, and further, produce the feeling of well-being not attained by the use of exogenous synthetic drugs.

**DI-OVOCYLIN*** (α-estradiol dipropionate), **OVOCYLIN*** (α-estradiol)

*Trade Marks Reg. U. S. Pat. Off. and Canada




—Goldzieher, Geriatrics, 1:226, 1946.

"Foremost among the anabolic hormones . . . with respect to its therapeutic usefulness in geriatrics is testosterone. Testosterone is the agent actually responsible for the greater muscular development and power of the male. . . . Distinction in treating males and females is necessary only in respect to dosage, for testosterone should be given to the elderly female within such quantitative limits as to forestall the appearance of signs of masculinization."

# PERANDREN

Trade Mark Reg. U. S. Pat. Off. and Canada (TESTOSTERONE PROPIONATE)

This pioneer brand of testosterone propionate provides the esterified male hormone in ampul form for injection. Perandren ampuls are ideal for initiating therapy, as their effect is the most potent of that produced by any of the available forms of testosterone. Medical investigation is continually widening the field of usefulness of Perandren, until its value is now utilized in almost every medical specialty.

## METANDREN LINGUETS FOR SUBLINGUAL ABSORPTION

Metandren Linguets—Trade Mark Reg. U. S. Pat. Off. and Canada (Methyltestosterone)

In many cases for which long-continued administration of testosterone is necessary, Metandren Linguets are often found the most convenient and economical medication. This unique Ciba-originated form of the hormone provides the ease of oral dosage with greater efficiency than is possible by ingestion. The Linguet is sublingually absorbed directly into the systemic circulation, by-passing the liver and thus greatly reducing the inactivation known to take place in that organ. Lisser (Cal. & West. Med., 64:177, 1946) states: "The most economical manner, and also efficient way of administering testosterone, is in the form of methyltestosterone, Linguets. . . . This route is two to three times as efficient as when the tablets are swallowed."

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# CORAMINE AMPULS

## IN SHOCK· ·IN CARDIAC DYSPNEA

# CORAMINE LIQUID

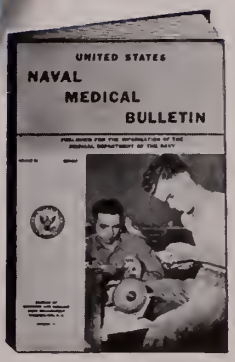
Give intravenous Coramine first, then follow with plasma, is the advice of Gunther[1] on treatment of shock. "There is no contraindication," he states, "for the use of the drug in the treatment of circulatory collapse, in shock from burns, traumatic and surgical shock, or from shock attendant on hemorrhage. The toxicity is very low. Thirty cc. have been given intravenously over a period of 30 minutes with beneficial results in the treatment of severe surgical shock."

## CORAMINE FOR ORAL ADMINISTRATION

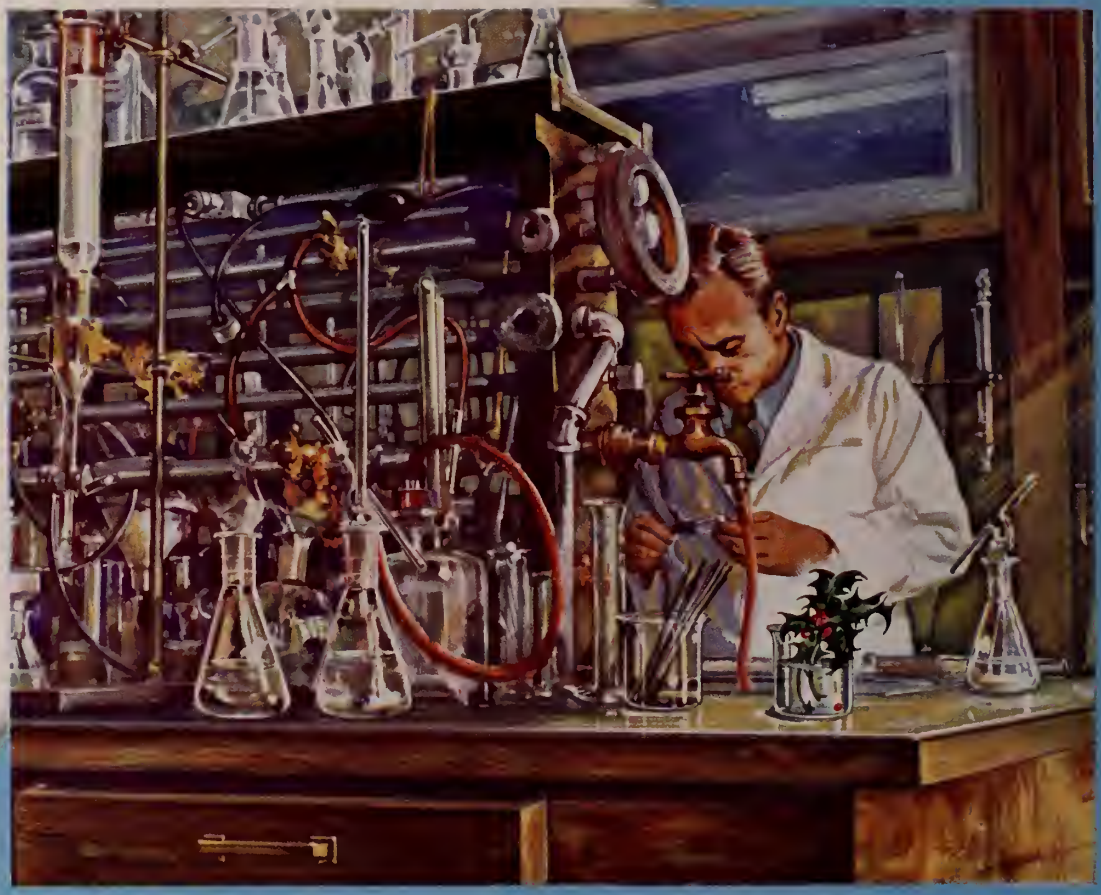
Coramine solution for oral administration has for over 20 years given gratifying results in cases of cardiac disease. Most striking of the results is the favorable action on the respiratory distress of these patients. Coramine orally results in a progressive relief, usually achieving maximal effect in a period of a few days. Brower and Korry (Northwest Med., 35:89, 1936) advise trial of Coramine in all patients subject to anginal attack or presenting other evidence of impaired coronary circulation. The margin of safety of Coramine and its lack of cumulative effect permit its use over extended periods of time.

Coramine—Trade Mark Reg. U. S. Pat. Off. and Canada
(Nikethamide)

CIBA




1. Gunther, L., U. S. Naval Med. Bull., 44:300, 1945.



# Holiday Greetings

**CIBA PHARMACEUTICAL PRODUCTS, INC.**

SUMMIT NEW JERSEY

In Canada: Ciba Company Limited, Montreal

Printed in U. S. A. 2/1111M

In nutritional anemias of children  adults  the aged 

..... anemia of menstrual abnormalities  .....

..... anemia of pregnancy  lactation .....

..... anemia of chronic blood loss  .....

convalescence from infectious diseases  surgery  etc. .....

Rx hepatinic
(McNeil)

—most readily assimilable form of iron (ferrous sulfate) combined with a unique, high-potency, predigested form of crude (unfractionated) liver concentrate—plus the factors of the vitamin B Complex—

—a hematinic agent and nutritional supplement, which you can be sure your patients—young, old or middle-aged—will take and continue taking—

—has a delightful flavor—and the dosage is small: one teaspoonful t.i.d. Supplied in pints and gallons.

The alcoholic content of Hepatinic is very low—making it safe for pediatric use. Tasting samples available on request.

McNeil

• Each fluidounce contains: Ferrous sulfate 12 gr., Crude Liver Concentrate 60 gr., fortified to represent Thiamine Hydrochloride 2 mg., Riboflavin 4 mg., Niacinamide 20 mg., together with pyridoxine, pantothenic acid, choline, folic acid, vitamin $B_{10}$, vitamin $B_{11}$, biotin, inositol, para-aminobenzoic acid and other factors of the vitamin B complex as found in crude (unfractionated) liver concentrate.

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STOP THE URGE TO SCRATCH

IN ITCHING, IRRITATIVE SKIN CONDITIONS with

ENZO-CAL

• PROMPT RELIEF

The mild anesthetic action of benzocaine quickly quiets the pruritus.

• PROTECTS AND AIDS HEALING

Semi-colloidal calamine and zinc oxide form a protective film over the affected area and aid healing.

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Patients appreciate its pleasing, greaseless vanishing cream base... doesn't stain clothing or linens.

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IN ECZEMA; PRURITUS ANI, VULVAE, and SCROTI; CHAFING; DIAPER RASH; EXANTHEMS

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# concentrated power

The greater the concentration, the more effective the results.

A combination of highly potent quantities of vitamins known to be essential in human nutrition, in balanced therapeutic amounts, as in THERA-VITA* capsules, supplies the concentrated power necessary for effective results in cases of hypovitaminosis.

*Thera-Vita* capsules represent a highly potent, multivitamin preparation which has been designed specifically to meet the patient's need for large doses of the vitamins either as a therapeutic measure or as a corrective supplement in dietary insufficiency.

*Thera-Vita* *therapeutic* multivitamin capsules are easily swallowed, tasteless, and well-tolerated.

Each THERA-VITA multivitamin capsule contains:

| | |
|---|---|
| Vitamin A (liver oil conc.) | 12,500 U.S.P. Units |
| Thiamine Hydrochloride ($B_1$) | 10 mg. |
| Riboflavin ($B_2$) | 10 mg |
| Niacinamide | 100 mg. |
| Pyridoxine Hydrochloride ($B_6$) | 1 mg. |
| Calcium Pantothenate | 10 mg. |
| Ascorbic Acid (Vitamin C) | 150 mg. |
| Vitamin D (Activated Ergosterol) | 1,250 U.S.P. Units |

*Bottles of 100's and 250*

Remember, doctor, THERA-VITA capsules are to be prescribed and not simply suggested to your patients. Help us to maintain the professional status of this product and to avoid its indiscriminate use by the laity without medical supervision.

OMNIS ORBIS WARNER ESTABLISHED 1856

WILLIAM R. WARNER & CO., INC. NEW YORK • ST. LOUIS

*Trademark Reg. U. S. Pat. Off.*






# c n e t a e power

The greater the concentration, the more effective the results.

A combination of highly potent quantities of vitamins known to be essential in human nutrition, in balanced therapeutic amounts, as in THERA-VITA* capsules, supplies the concentrated power necessary for effective results in cases of hypovitaminosis.

capsules represent a highly potent, multivitamin preparation which has been designed specifically to meet the patient's need for large doses of the vitamins either as a therapeutic measure or as a corrective supplement in dietary insufficiency.

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| | |
|---|---|
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| Thiamine Hydrochloride ($B_1$) | 10 mg. |
| Riboflavin ($B_2$) | 10 mg |
| Niacinamide | 100 mg. |
| Pyridoxine Hydrochloride ($B_6$) | 1 mg. |
| Calcium Pantothenate | 10 mg. |
| Ascorbic Acid (Vitamin C) | 150 mg. |
| Vitamin D (Activated Ergosterol) | 1,250 U.S.P. Units |

*Bottles of 100's and 250*

OMNIS ORBIS
WARNER
ESTABLISHED 1856

Remember, doctor, THERA-VITA capsules are to be prescribed and not simply suggested to your patients. Help us to maintain the professional status of this product and to avoid its indiscriminate use by the laity without medical supervision.

*Trademark Reg. U. S. Pat. Off.*

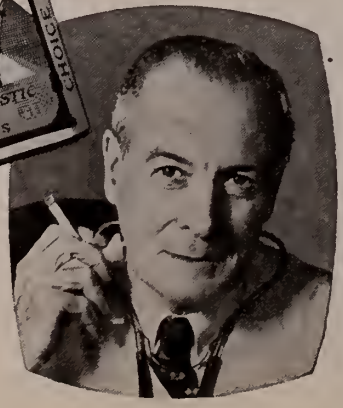


# The Doctors behind the Doctor




● Magical penicillin . . . the amazing "sulfas"... and now the new streptomycin . . . Thank the men of research medicine for those . . . and for all the other valuable aids they have placed in the doctor's "little black bag."

Biochemists and bacteriologists . . . pathologists and physiologists . . . whatever the field of research . . . they are, first and foremost, *doctors!* And, like all doctors, they are tirelessly devoting their lives to the cause of human health and happiness.



R. J. Reynolds Tobacco Company. Winston-Salem, N. C.

According to a recent independent nationwide survey:

MORE DOCTORS SMOKE CAMELS

*than any other cigarette*



# Safe Support

THE MENOPAUSAL PATIENT will welcome this efficient assistance in negotiating the decline of ovarian activity with untroubled calm.

Natural estrogens are preferred by many physicians and patients because they are readily tolerated and produce relatively few undesirable side effects.

## PLESTRIN

REG. U. S. PAT. OFF.

*in Oil*

### NATURAL ESTROGENS IN OIL
### HARROWER

Biologically standardized to assure effectiveness and uniform potency.

SUPPLIED: In strengths of 2,000; 5,000; 10,000 and 25,000 I.U. per cc., in sterile ampuls and in sterile multiple-dose vials.

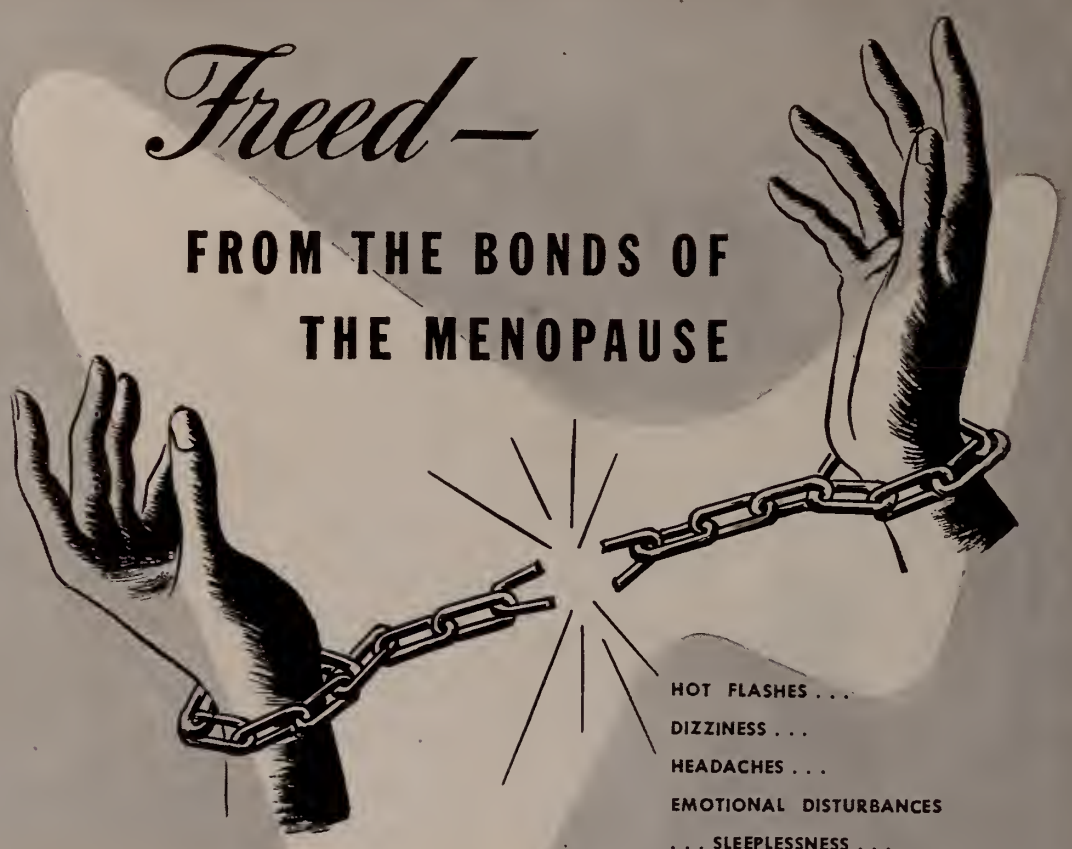
PLESTRIN capsules are available in strengths of 1,000 and 4,000 units each for oral administration.

THE HARROWER LABORATORY · GLENDALE CALIFORNIA · *at Your Service*

*The* HARROWER LABORATORY, *Inc.*
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**FROM THE BONDS OF THE MENOPAUSE**



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**HEADACHES . . .**
**EMOTIONAL DISTURBANCES**
**. . . SLEEPLESSNESS . . .**

**SYMPTOM CONTROL** with Conestron is often a valuable aid to a smoother, more rapid adjustment to the natural internal changes which occur during the climacteric.

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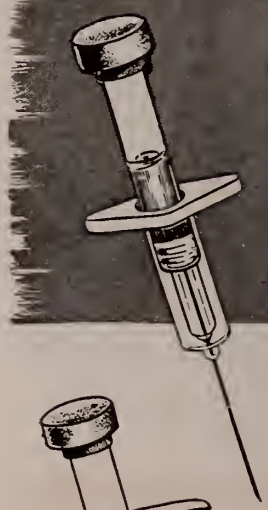
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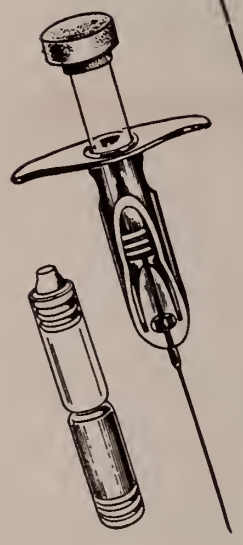
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The Illinois Medical Journal

December, 1946

VOL. 90, NO. 6

Official Journal of the Illinois State Medical Society

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# Editorials

## COUNTY HEALTH DEPARTMENTS

During the past six months officers of the Illinois State Medical Society have received many letters asking for information concerning previous actions taken by this Society relative to county health departments, as provided under the Searcy-Clabaugh Act, which was approved in this state in 1943.

When the Searcy-Clabaugh Bill was introduced in the State Legislature, the Illinois State Medical Society approved the bill and this information was presented to the committee before which the bill was referred for study and subsequent hearings. Representatives of the Society appeared at these hearings at the request of the Chairman. The bill was subsequently passed and approved by the Governor.

Since its enactment there have been a considerable number of counties or one or more adjoining counties which have approved the program as outlined in the Act, and they have developed their own local health departments, these being supervised and operated entirely on a local basis.

At the annual meeting of the American Medical Association House of Delegates in 1942, a resolution was passed calling for the development as rapidly as possible of complete territorial and population coverage in the Continental United States with modern full-time public health organizations on a county, joint county, or district basis.

Within the past month a letter has been received in the offices of the secretaries of the state medical societies from the Bureau of Health Education of the A. M. A., with which was enclosed a copy of the A. M. A. resolution, and urging that each state society at the first opportunity present same before their own House of Delegates, to get either approval of a similar resolution or re-affirming of a previous action of a similar nature, so that all state societies will be on record in the same manner as the A. M. A., favoring the creation of local full-time health departments.

This is one of the points called for in the latest revision of the Platform of the American Medical Association, and it has already been approved by many of the constituent state societies since 1942. The Resolution as approved by the A. M. A. in 1942 is as follows:

"Whereas, a major inadequacy in the civilian health protection in war as in peace time continues from the failure of many states and of not less than half the counties in the states to provide even minimum necessary sanitary and other preventive services for health, by full-time professionally trained medical and auxiliary personnel on a merit system basis supported by adequate tax funds from local and state and

where necessary from federal sources; therefore be it

Resolved, that the Trustees of the American Medical Association be urged to use all appropriate resources and influences of the Association to the end that, at the earliest possible date, complete coverage of the nation's area and population by local, county, district or regional full-time modern health services be achieved."

The above is taken from the Proceedings of the House of Delegates of the American Medical Association held at Atlantic City, June 8-12, 1942.

Reports received from those counties in Illinois where full-time local health departments are now in operation, would indicate that in the majority of these localities the medical profession seems to be satisfied with the operation of the departments and believe that the public health is materially improved through their operation. In two or three counties there seems to be a difference of opinion on the part of the medical profession, and in one county where such a program has been in operation on a temporary basis, the society has not approved the plan.

In accordance with the request of the American Medical Association, the above resolution will again be presented before the House of Delegates of the Illinois State Medical Society at the 1947 annual meeting, with the accompanying letter for whatever action seems desirable by the members of the House. From reports received from other state medical societies in efforts to get their reactions of the program in their respective states, and their opinions of local health departments on a full-time basis, it seems quite logical to conclude that Illinois has been rather backward in developing the plan in this state.

In quite a number of states at the present time, all counties or practically every county


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within the individual states now has this health protection through full-time local health departments, and the vast majority of those to whom our letters were sent heartily endorse the program. If there are flaws in the present Illinois Act, which provides for the creation of local full-time health departments, these should be noted and should be called to the attention of our legislature at the next regular session, for Illinois should be a leader in all movements to improve the public health of its people.

## A CENTURY OF PROGRESS IN ANESTHESIA

Throughout the world the centennary of the application of surgical anesthesia was celebrated on October 16, as Horace Wells and W. T. G. Morton, both dentists, on October 16, 1846, gave ether in a surgical case at Massachusetts General Hospital in Boston. The success of this application was publicized far and wide. Four years previously Crawford W. Long of Georgia began to use ether as an inhalation anesthesia, and in the four years following, until the publicization of the work of Morton, the outside world knew but little concerning ether as an inhalation anesthetic. Consequently many insist on giving Morton the principal credit for its use.

Sir William Osler, many years ago, stated that anesthesia was medicine's greatest gift to suffering humanity, and no doubt this statement is correct.

In recent years a sizable controversy has developed among those who believe that Morton and Wells deserve more credit for the establishment of inhalation anesthesia as a boon to humanity and a safe procedure, than the country doctor, Crawford W. Long, whose use of ether in this capacity predated the efforts of Morton-Wells by four years.

Regardless of who receives a priority rating for this achievement, there seems to be no logical reason for not giving credit to all three for their outstanding work and their courage in experimenting in a field which, up to that time, had not been given much consideration.

For many years the use of ether, chloroform and nitrous oxide in inhalation anesthesia was established as a universal procedure, although hypodermic injections for pain were first used in 1839. Cocaine injections for local anesthesia were first used in the early "'70's", then following this application, other local anesthetics were developed gradually.

Ethylene, cyclopropane and other gaseous anesthetics used by the inhalation method have been used since 1918, following the research work of Luckhardt and Thompson. In more recent years the use of intravenous anesthetics has been developed, these being members of the barbiturate family. Pentothal sodium has probably been the barbiturate of choice in intravenous anesthesia, usually administered intravenously in a 2½% solution, and from mild to moderate muscle relaxation is produced within less than one minute. This is of more value in securing relaxation of muscles of the extremities than in any other field. In view of the fact that in abdominal operations, to get complete relaxation, the dosage necessary so closely approximates the lethal dose, it is usually necessary to use some other anesthetic with it — and especially nitrous oxide inhalations.

Likewise in recent years the use of spinal analgesia has become a common procedure for many types of operations. The analgesia is confined to the area supplied by the nerve roots affected by the drug. Complete muscular relaxation is produced through its use, but on account of the tendency to produce hypotension, spinal analgesia is not advisable in cases of shock where immediate surgery is indicated. Although procaine is the drug usually preferred in spinal analgesia, there are a number of other similar preparations which may be used, the choice apparently depending upon the individual desire of the operator.

Efficient refrigeration has been used recently, especially in amputations of the lower limbs, and a considerable amount of literature on its use has appeared in medical literature during the past five years. Anesthesia and its proper and safe application are actually a development of the past century. Nearly every decade, especially since 1860, has seen the development of something new used as an anesthetic agent.

Beginning with the work of Long, Wells and Morton a century ago, we have seen the trends gradually change, with a period when much less ether was used than in other periods; today, however, there seems to be a return to the use of ether in many surgical procedures as the

anesthetic of choice. This apparently is well illustrated in the case of thoracic surgery, as many of the outstanding surgeons in this field rely on ether as the choice of anesthetics in many of the highly technical procedures in their field of work. Mortality statistics from such procedures as lobectomy, pneumonectomy, resection of the esophagus, and in the various types of operative procedures on the human heart, have all come down rapidly during the past ten years.

The past century has brought much to suffering humanity, for the relief of pain in general, and in making surgical procedures entirely painless.

No one today would venture to give an opinion as to what the next century may bring, but with recent progress in all branches of medicine and surgery, almost anything can be developed, so it is entirely possible that many of the dreaded diseases of today for which but little can be done, may respond favorably to some of the research developments of tomorrow.

## CASE REPORTS FOR THE JOURNAL

The Editor has received recently for publication in the Illinois Medical Journal, some fine short case histories which will appear in future issues. Many physicians have unusually interesting cases which should be reported when properly worked up. The reports should be short and to the point.

This Journal has a competent Editorial Board composed of prominent members of the Society in different fields of work. When the Board meets to consider many problems in connection with the scientific presentations selected for publication, these case histories are also submitted by the editor for official action by the Board. Occasionally a case history is not approved for publication because it does not prove definitely the diagnosis as presumed by the writer, or for some other reason the Board considers of sufficient importance to withhold publication.

At a recent meeting of the Editorial Board, it was the unanimous opinion that we should have a regular section reserved in the Journal for case reports, and when a group is accumulated, they should be published as a definite section.

Also at this meeting the Editorial Board expressed a desire to have members of the Illinois State Medical Society express their opinions relative to the Journal, make criticisms and suggestions so that the desires of the members and what they prefer to see in their Journal, can be published each month. Any communications received by the editor in the future along this line will be referred promptly to the Board so that consideration may be given these requests.

The Illinois Medical Journal is owned and operated by the Illinois State Medical Society, and the Council is responsible for its publication each month. It is not the intention of those responsible for the publication of the Journal to make money from its pages, but to give the members what they desire along the line of scientific articles, editorials, correspondence of interest, and to carry several departments presenting information of interest to the readers.

During the past year the section, "News of the State" has been enlarged so that information concerning activities of the county medical societies and the individual members can be published each month. The reference committee in the House of Delegates to which the annual report of the editor was referred, heartily approved the enlargement of this section and recommended that it be continued along the same line in the future. The recommendation of the reference committee was unanimously approved by the House of Delegates as a whole.

It is hoped that members of the Society will write up their unusual case histories giving complete information of interest to readers, yet not occupying too much space, as the brief reports properly written are of the greatest reader value. These case histories should be sent to the editor and he in turn will refer them to the Editorial Board to give final approval for publication.

## CALL FOR SCIENTIFIC EDITORIALS ELIGIBLE FOR $300 IN PRIZES

At a recent meeting of the Editorial Board of the Illinois Medical Journal, it was unanimously agreed that our Journal should published each month a scientific editorial, and that this information was to be given to the membership of the Society in an early issue of the Journal.

Several editorials of this type have been published, or will be published in the near future, and it is the desire of those responsible for the

publication of this Journal that members of the Illinois State Medical Society submit material of this type to the Editor.

It will also be recalled that during the present fiscal year which ends next May, awards will be made to the members submitting the best scientific papers for publication, or the best scientific editorials. The awards will be in two classes:

1. For the best written article to be passed upon by literary and scientific people.

2. For the outstanding piece of original work as presented in a paper.

It was specifically stated that this is to apply to original scientific articles and scientific editorials. For the first class a prize of $100.00 is to be awarded and for the second class the award will be $200.00. This recommendation of the Editorial Board was approved by the Council, and all papers and scientific editorials published in the July, 1946 Illinois Medical Journal, and all to be published prior to June, 1947, will be eligible for these awards.

Scientific editorials written by members of this Society will therefore be eligible for one of these awards, and it is hoped that a supply of editorials suitable for publication will be received in the near future.

---

## NEW RULING FOR A.M.A. RESOLUTIONS

At the 1946 annual meeting of the American Medical Association held in San Francisco, a resolution was introduced which would make it necessary for resolutions to be introduced before the House of Delegates to be submitted to the Secretary-General Manager thirty days prior to any meeting of the House. They are to be published in the Journal of the American Medical Association as well as in the handboook sent to members of the House prior to the meeting.

The House of Delegates approved this resolution and it will be in effect for the mid-year meeting to be held in Chicago in December. In this resolution the Secretary of the A.M.A. is to write each constituent state medical society asking that resolutions to come before the House be sent to him as far ahead as possible before the meeting. He is directed to submit mimeographed copies of each resolution to the delegates so that each will have copies available and know what resolutions are to be discussed.

Many times in recent years delegates have introduced resolutions on the final day of the session asking that they receive immediate attention. But since they require more than a majority of the votes to be approved when not previously submitted, it is rare indeed when these resolutions are approved. Quite often these last minute resolutions are promptly tabled as there is no opportunity to refer them to committees and permit hearings which may be attended by members desiring to procure information concerning them.

This new arrangement seems to be a step in the right direction, and every delegate will have a copy of all resolutions, and will have an opportunity to go over them thoroughly and vote more intelligently when action is requested on the part of the House. This is a step which, in the opinion of many, could be adopted by the various state medical societies relative to resolutions to be submitted at the state level.

Each state society was urged to present this before its own House of Delegates so that all will know of the new ruling, and perhaps recommend that it be adopted at state meetings. Too often when long resolutions are presented and read before the House many members become confused. If copies were mimeographed and made available for all delegates so they could go over them thoroughly, no doubt wiser decisions would be made when issues come to a vote. This is unquestionably a step in the right direction and worthy of emulation in all state societies.

**THE JOURNAL WISHES ITS READERS A**

*Happy New Year!*

# State Department of Public Health

## INFECTIOUS DIARRHEA — A PUBLIC HEALTH PROBLEM

Statistics at best do not make for spectacular reading but there are some data which will interest every physician, nurse, hospital administrator and mother who has anything to do with infant care.

Infantile diarrhea, second only to acute respiratory diseases as a leading cause of infant mortality, was responsible for 135 deaths in Illinois during the first nine months of 1946. Forty-one of these cases were under one month of age while the remaining 94 were between one and twelve months. As seen in the accompanying table, these deaths showed no seasonal variation. The great majority occurred in 43 hospitals while an appreciable number took place in the home. They were not limited to any particular locality as deaths were reported from 37 counties scattered throughout the State. The total of 135 represents an increase of 8 over the number attributed to the same cause for the corresponding period of 1945.

Much of this mortality was due to outbreaks of diarrhea occurring in neonatal nurseries. Practically all diarrheal deaths under the age of one month and a small percentage of those in the two month age group were known to be due to infectious diarrhea. Thus approximately one-third of the deaths were due to this one cause alone. Undoubtedly the remaining two-thirds include other cases which may be attributed to a similar or the same infectious agent.

It is unfortunate that so little is known about the causative agent and mode of transmission of infectious diarrhea. In spite of numerous outbreaks throughout the country, facts relating to the etiology and epidemiology are few. Research now in progress promises to shed some light on the problem but to date reliance must be placed on the strict observance of acceptable techniques in nursery management. Infectious diarrhea outbreaks are explosive in character often with high case fatality rates. Present day crowding in hospitals and limited personnel add to the risk. It cannot be emphasized too strongly, therefore, that observance of acceptable techniques at all times is of paramount importance. Through this means only can the disease be limited to the individual case once it occurs. Herbolsheimer[1], in a recent review of infectious diarrhea, has outlined the factors contributing to the origin and spread of this disease and the steps involved in treament, prevention and control. The active interest of physicians, nurses and hospital administrators in the measures there proposed and prompt reporting of actual or sus-

Number of Infant Deaths Due to Diarrhea Reported in Illinois, January to September, 1946

| Month | Place of Occurrence | | Total |
|---|---|---|---|
| | Home | Hospital | |
| January | 3 | 18 | 21 |
| February | 3 | 18 | 21 |
| March | 4 | 11 | 15 |
| April | 3 | 8 | 11 |
| May | 1 | 15 | 16 |
| June | 5 | 18 | 23 |
| July | 4 | 7 | 11 |
| August | 1 | 7 | 8 |
| September | 3 | 6 | 9 |
| | 27 | 108 | 135 |

1. Herbolsheimer, H., Infectious Diarrhea of the Newborn, Ill. Med. J., 90: 6-9, July, 1946.

pected cases to public health authorities can help materially to reduce this loss of infant life.

To this must be added the need for informing mothers of newborn infants as to the significance of infantile diarrhea and the proper care of infants. Enlisting the services of a physcian promptly in the event of such illness will give physicians additional chances for saving infant life.

## INFLUENZA VACCINE DEMONSTRATION

Army experience during the past year indicated that influenza vaccine was effective in protecting military personnel. This product now has become available for civilian use. Consequently the State Department of Public Health, in cooperation with the authorities of several universities and normal schools in Illinois, is taking advantage of this opportunity to test further the efficacy of this new immunizing agent. Studies will be conducted under the supervision of medical authorities at Northwestern University, University of Illinois and State Normal Universities at Carbondale and DeKalb.

The vaccine used combines Type A and Type B attenuated influenza virus. After a single subcutaneous injection of 1 cc., immunity develops within a period of several weeks. The duration of such immunity is relatively short, lasting probably 3 or 4 months. Reactions consisting of malaise, fever, and arthralgia, have been reported in so-called normal individuals but they are not serious and are usually of short duration. It is claimed that persons sensitive to eggs and those who have or have had active tuberculosis should avoid injections of this product.

Due to the relatively high cost of influenza vaccine and the lack of presently available funds, the State Department of Public Health is unable to distribute this material to physicians throughout the State. The limited supply for the present, therefore, will be confined this year to population groups were, because of unusual living or working conditions, the risk is greatest. Such conditions prevail in the educational institutions mentioned, and the results of the demonstrations will be viewed with considerable interest.

## SYMPOSIUM ON CANCER

A five-day symposium on cancer, with special emphasis on early diagnosis and treatment, will be conducted by the Illinois Division of the American Cancer Society in Chicago, January 20 to 24. The program has been approved by the Council of the Illinois State Medical Society and the Illinois State Department of Public Health. The following committee is in charge of arrangements for lectures, conferences and clinics to be held at their respective medical schools:

Dr. Warren H. Cole, chairman
Professor of Surgery, University of Illinois
Dr. Alexander Brunschwig,
Professor of Surgery, University of Chicago
Dr. Loyal Davis,
Professor of Surgery, Northwestern University
Dr. Herbert E. Schmitz,
Professor of Gynecology and Obstetrics, Loyola University

Sessions on the fifth day will be held at Michael Reese Hospital. Special dinner meetings are planned.

Invitations have been extended to county medical societies with the request that physicians be recommended for attendance by each society. Attendance will be limited to thirty-six "downstate" physicians, selections being made in the order of receipt of application. The major portion of the expenses of physicians attending will be borne by the American Cancer Society.

The program will be repeated if indicated by the number of applications. Plans call for a similar symposium for Cook County physicians at a later date.

# Correspondence

## FELLOWSHIP IN A. M. A. IS RECOMMENDED

The American Medical Association is going to celebrate its centennial in Atlantic City, June 9-13, 1947. Elaborate plans are being made for this celebration.

Only Fellows and Invited Guests are eligible to attend. Membership in your state society is the primary qualification for Fellowship in the A. M. A. Fellowship dues and subscription to the Journal A. M. A. are both included in one annual payment of $8.00, which is the cost of the Journal to subscribers who are not Fellows.

If you are not a Fellow and plan to attend the Atlantic City session, which will be a milestone in medical history, you can save yourself considerable time and confusion when registering, if you will write now to the American Medical Association, 535 North Dearborn Street. Chicago 10, and ask if you are eligible to become a Fellow.

## NATIONAL GASTROENTEROLOGICAL ASSOCIATION 1947 AWARD CONTEST

The National Gastroenterological Association announces its Annual Cash Prize Award Contest for 1947. One hundred dollars and a Certificate of Merit will be given for the best unpublished contribution on Gastroenterology or allied subjects. Certificates will also be awarded those physicians whose contributions are deemed worthy.

Contestants residing in the United States must be members of the American Medical Association. Those residing in foreign countries must be members of a similar organization in their own country. The winning contribution will be selected by a board of impartial judges and the award is to be made at the Annual Convention Banquet of the National Gastroenterological Association in June of 1947.

Certificates awarded to other physicians will be mailed to them. The decision of the judges will be final. The Association reserves the exclusive right of publishing the winning contribution, and those receiving certificates of merit, in its Official Publication, the Review of Gastroenterology. All entries for the 1947 prize should be limited to 5,000 words, be typewritten in English, prepared in manuscript form, submitted in five copies, accompanied by an entry letter, and must be received not later than April 1, 1947. Entries should be addressed to the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

## THE WOMAN'S AUXILIARY TO THE ILLINOIS STATE MEDICAL SOCIETY PRESIDENT'S MESSAGE

It is traditional, at the beginning of a new year, to resolve hopefully on a better way of living, a better job done and fewer tasks left unfinished at the close of the year. As I bring you greetings, I hope that each of you will resolve to keep in mind the aims, ideals and purposes of the Auxiliary, and that you will accept them as your duty and obligation.

This year the Auxiliary has been asked to take up the job of "Selling an Idea" — the idea of voluntary medical insurance. The most urgent need is to put the Ten-point Program into action. The general public still needs to be educated to

the understanding that the patient loses the most under socialized medicine. It has been recommended that in carrying out this program, each Auxiliary should arrange study groups, and have their well-informed members ready at all times to present the plans to lay organizations in which they participate. May I urge that the Auxiliary members keep a close watch on all legislative matters.

Again the Medical Society has asked the Auxiliary to carry on in their collection of the Benevolence fund. It is our hope, and our sincere desire that the time will come when no one who needs this fund shall find it lacking because of our failure in making it adequate.

In closing I want you to know that I desire to work with you in every way possible towards the accomplishment of our objectives.

MRS. E. W. BURROUGHS

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## WOMAN'S AUXILIARY TO THE ILLINOIS STATE MEDICAL SOCIETY

1946-1947

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# Original Articles

## THE MANAGEMENT OF ACUTE CRANIOCEREBRAL TRAUMA

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The first five to six days following craniocerebral trauma are the most crucial, not only for the sustaining of life but for the preservation of the fullest possible neurologic and psychologic function. Effective management during this critical period requires the exercise of certain guiding principles and empirical considerations as they bear upon diagnosis, prognosis and therapy. The purpose of this paper is to present these in a manner comprehensible to the general practitioner and surgeon under whose care necessarily falls the bulk of such injuries.*

In the management of the most severe cases a wide background of experience in neurology and neurosurgery is, of course, a valuable asset. Yet for most cases such is not an indispensable prerequisite to competent management, and even if it were the very practical circumstance would still require to be met that the services of a trained neurosurgeon are not accessible to most communities; nor is it likely they will be for some time to come. The responsibility for administering early care to head-traumatized patients can scarcely be avoided by the active general practitioner and surgeon. With the exception of epidural hematomas and widely exposed vault defects with extruded brain, few conditions demand a neurosurgical procedure within the first 24 hours. But during this period the institution of appropriate conservative measures is urgently required and if so administered may well turn the tide in the patient's favor. Their neglect, on the other hand, may so imperil his condition as to render him irrecoverable even if expert help subsequently becomes available.

Motor vehicular and occupational accidents, blows and falls account for the great majority of head injuries[41]. Irrespective of the promptness and appropriate character of the treatment administered, 8-12 percent of hospitalized cases succumb within the first week owing to the gravity and irreversibility of the imposed brain insult[39, 40, 50, 61]. Of these, slightly over half die within the first 8 hours and 65 percent within the first 24 hours. On the other hand, some 70 percent of hospitalized cases survive, apparently irrespective of the mode of treatment so long as it is not negligent or actually noxious. Relatively few cases, probably not more than 4-6 percent of an unselected group, can properly be considered to benefit from neurosurgical operations.†

Read at the 1946 Meeting of Illinois State Medical Society, Tuesday, 14 May, 4 p.m., Chicago, Illinois.

*No attempt will be made in this paper to deal with the special circumstances[21, 21, 26, 36] that require consideration in war wounds of the head. Nor will an attempt be made to describe actual operative techniques. Such are available in general and special text books[16, 26].

†The number of patients actually subjected to operation appreciably exceeds these figures, varying from clinic to clinic and from year to year within a given clinic. Thus, at Boston City Hospital, the overall operative rate for several years prior to 1938 was 36.9 percent[40], whereas at Bellevue and Kings County Hospitals the rate over a corresponding period remained under 15 percent. Some of the factors responsible for these disparities are (a) the selection

There remains, then, a group comprising 12-16 percent of hospitalized patients regarding whom the outcome for life and function depends upon the effectiveness of the conservative medical and nursing measures employed. It is for this group that the general practitioner should "point" himself.

If the concept be accepted that proper therapy depends upon proper diagnosis, it is incumbent upon the practitioner to equip himself as far as possible with those tools by means of which he may reliably infer from a study of the patient's disabilities the existence, character, site and extent of the responsible pathologic agent. Besides being able to elicit the more important signs and symptoms and to recognize their more familiar constellations, he must possess a useful fund of anatomic and physiologic knowledge and must keep clearly before him a mental catalogue of the numerous pathologic processes that may obtain in any given case. Against the latter he must constantly measure the demonstrable clinical findings. For this reason the overt and covert pathological findings that are most commonly encountered in craniocerebral trauma are itemized below.

MARKS OF VIOLENCE ON SCALP, FACE, NECK AND TEETH

I. Abrasions (including "brush burns") and contusions.

II. Lacerations and Avulsions
scalp, eyelid, globe, iris, nose, pinna, lip, tongue, gum and cheek (external and/or mucosal aspects).

III. Ecchymoses and Edema
A. General: scalp, facial and neck tissues.
B. Special:
1. Periorbital (if delayed, suggests fracture of frontal bone, base and/or vault)
2. Postauricular (if delayed, is presumptive evidence of fracture of petrous-temporal bone — "Battle's sign")

IV. Subcutaneous Emphysema
1. Forehead (with fracture into frontal sinus)
2. Cheek and Nose (with fracture into antrum)
3. Neck (with tracheal fracture and lung puncture)

V. Hemorrhage
A. Free:
1. Lacerations and Avulsions
2. Epistaxis
3. Pharyngeal
4. Middle Ear
} All suggest basilar fracture; and if associated with cerebrospinal fluid are conclusive evidence thereof.

B. Trapped:
1. Subaponeurotic (cephalhematoma)
2. Intra-ocular
3. Retinal (with or without detachment)
4. Retropharyngeal (suggests cervical fracture-dislocation)
5. Tympanic cavity (without rupture of drumhead)

VI. Imbedded Foreign Bodies
dirt, gravel, cinders, twigs, fragments of glass, stone, wood, metal, pieces of hat, etc.

VII. Loosening, fractures and evulsion of teeth.

It not infrequently happens that unconscious patients lacking a satisfactory history are brought to the physician's attention. These cases raise the entire problem of the differential diagnosis of coma of which craniocerebral trauma constitutes but one item. The absence of marks of violence should not be interpreted as excluding severe cerebral trauma and, on the other hand, their mere presence should not deceive the examiner into supposing that craniocerebral trauma is the sole or even the major responsible factor at work. Obviously, syncopes arising from many causes — diabetes, hyperinsulinism, apoplexy, cardiac catastrophe, drug intoxication, etc., — may be complicated by a fall and the latter may produce external marks of violence which have no significant cerebral counterpart. Again, cerebral trauma secondary to a fall may be added to the original cause of syncope. A wary and self-critical attitudinal set will serve the diagnostician well in all such instances.

of patients for hospitalization; (b) the diagnostic skill of the staff; (c) the indications adopted for surgical intervention; and (d) the interpretation as to what kinds and magnitude of lesions may be successfully dealt with by operation.



Fig. 1. Compound, Comminuted, Stellate Fracture of Parietal Vault. Note Subaponeurotic Hematoma overlying Fracture Site.



Fig. 2. Linear Fracture of Parietal Vault with Dehiscence of Interparietal suture at Vertex of Skull.

INJURIES TO THE BONES OF THE SKULL, FACE AND NECK

A. Fractures of Skull (Simple and Compound). Located as of the Vault, Base or Both. (Figures 1, 2, 3)
   1. Linear
   2. Penetrating
   3. Perforating
   4. Comminuted
   5. Stellate, Bursting
   6. Depressed (linear, comminuted, pond, gutter and disc types)
   7. Dehiscence of sutures

B. Fractures and/or Dislocations of Face (Simple and Compound) Located as of the Nose, Malar bone, Maxilla, Zygomatic arch, Glenomaxillary joint and Mandible (usually bilateral)
   1. Linear
   2. Penetrating
   3. Perforating
   4. Comminuted
   5. Depressed

C. Fractures and/or Dislocations of Cervical Spine (usually simple and at C5-6), with or without spinal cord dysfunction. (Figure 4)
   1. Compression ("wedging") of body
   2. Facets, pedicles, laminae, odontoid process
   3. Anterior or posterior subluxation with ligamental tears.

Orificial bleeding should immediately suggest to the examiner the possibility of fracture of the base of the skull, compounded through the paranasal sinuses, middle ear or mastoid cells. Epistaxis and pharyngeal bleeding suggest basilar fracture into the anterior and middle fossae, whereas aural bleeding is presumptive of fracture into the middle or posterior fossae. In the latter fractures, appreciable bleeding from the fracture lines will rupture the drumhead and appear in the external canal. Smaller amounts however may not break through but can be recognized as bulging, bluish-red drum head ("hemotympanum"). The orificial discharge of cerebrospinal fluid or the latter mixed with blood permits a positive diagnosis of basilar fracture, irrespective of the x-ray findings.* The admixture of cerebrospinal fluid with a grossly bloody discharge may be detected by allowing a droplet

*Vance showed in an extensive series that over 25 percent of basilar fractures demonstrated at necropsy escaped detection by X-rays[54].



Fig. 3. Depressed Fracture of Occipital Bone, Pond type (of degree not sufficient to require elevation).

to fall on the pillow case. The rapid development of a clear "wet" ring peripheral to the red stain betrays the presence of cerebrospinal fluid.

The not uncommon association of injuries of the cervical spine and cord[13] with head injuries and the frequency with which such complications are overlooked require special comment. Fracture-dislocations of the cervical vertebrae and, in less severe cases, symptomatic myositis and ligamentitis, are particularly easily produced when physicial violence is delivered to the forehead, nasion or fronto-vertical regions. Abrasions at these sites should put the clinician on guard against cervical complications. Nuchal pain and rigidity may be wrongly interpreted as indicative of meningeal irritation due to subarachnoid bleeding, and the neurologic consequences of concussion, edema or hemorrhage of the cervical cord may be erroneously imputed to the brain injury.

On occasion, a cervical dislocation may be momentarily produced by a frontally-delivered impact. Such may spontaneously reposit, yet leave behind it serious neurologic deficits. X-rays of the cervical spine, being non-revelatory, may then mislead the unwary examiner. In cases of this sort, bulging of the posterior pharyngeal wall as demonstrated by clinical examination or röentgenography is strongly suggestive of occult retropharyngeal hemorrhage secondary to a tear of the prevertebral soft tissues.



Fig. 4. Fracture-dislocation of 6th Cervical Vertebra with posterior displacement due to blow on Forehead. This patient had a Cervical Hematomyelia and Tetra-Paresis.

INJURIES TO THE INTRACRANIAL CONTENTS

(Brain, Meninges, Blood and Blood Vessels, Cerebrospinal Fluid and its Cisterns, Ventricles and Channels)

I. Concussion ("Commotio Cerebri")

II. Laceration and Contusion (direct; contrecoup)
   1. Dura mater and/or venous sinuses
   2. Pia-arachnoid
   3. Cortex (cerebral and/or cerebellar)
   4. Brain stem

III. Hemorrhage

A. Collections of Magnitude Amenable to Surgical Removal:

1. Epidural (anterior and middle meningeal arteries)

2. Subdural (commonly of venous origin; but may be from smaller arteries or arterioles and lacerated cisterns)
   a. Hematoma
   b. Hemohygroma

3. Intracerebral (in cerebral hemispheres and cerebellum only; those of medulla, pons, midbrain, thalamus and basal ganglia are not amenable to surgery)

4. Intraventricular (only occasionally successful and must be done early)

B. Extravasations, Punctate and Interstitial Hemorrhages, Diffuse or Focal — Not Amenable to Surgical Removal.
1. Subarachnoid
2. Subpial
3. Intracortical
4. Intracerebral (including corpus callosum)
5. Within pericellular spaces and perivascular spaces of Virchow-Robin

IV. Brain Edema
1. Diffuse
2. Focal
3. Circumferentially Spreading
4. "Persistent" type of Trotter[51]

V. Intramolecular Derangement*
1. Sluggishly reversible with minimal outfall of cells
2. Irreversible with much outfall of cells.

With respect to certain of the above-itemized lesions, e.g., epidural, subdural and gross intracerebral clots, one encounters little difficulty in imagining a direct pathophysiologic relationship between the morbid process and clinical manifestations. Such interpretations, however, may not altogether encompass the pathogenetic circumstances actually in process. There is a lamentable readiness on the part of some pathologists and surgeons to regard other readily demonstrable lesions, such as cerebral contusion and laceration, subpial, subarachnoid and diffuse petechial hemorrhages, and variform zones of edema, as sufficient explanation of the symptomatology, clinical course and death of the patient. Serious reservation as to the tenability of these uncritical accounts was expressed in a previous article (9) on the grounds that (a) in fatal cases it is often impossible to demonstrate such lesions and (b) in non-traumatic diseases, cerebral surgery frequently results in laceration, contusion, edema and subpial and subarachnoid hemorrhages without producing clinical manifestations comparable to those met in the injured patient. It would appear, then, that not withstanding the concomitant presence of gross lesions, craniocerebral trauma commonly imposes upon the brain an occult factor (or set of factors) the pathogenetic significance of which may in some instances surpass that of the readily identifiable lesions and which in any case requires recognition. In the average discourse on head injuries, such common denominators as cerebral concussion and intramolecular derangement† are not given the emphasis they deserve. This practice does not, of course, make them less genuine or less dynamic pathogenetic factors.

In the past, the term concussion has been loosely used, at times referring to the mechanical jarring (*commotio cerebri*) of intracranial contents, at others to the disorders of function and clinical disturbances, and at still others to the pathologic findings in the brain. Fortunately, recent physiologic and histologic studies [2, 18, 19, 45, 55, 59, 60] have made it possible to formulate a self-consistent account of concussion in the following manner. Physicial violence to the head imposes a mechanical force directly upon larger or smaller masses of nerve cells. The dissipation of this force is in accord with the laws of hydrostatics and hydrodynamics, with certain minor qualifications arising from anatomic and torsion factors. The result is a generalized and fairly simultaneous discharge of stored neural energies, i.e., "depolarization" of the cell membranes occurs, whereupon there obtains an intense but short-lived excitation of the muscles and glands upon which the activated neuronal axones ordinarily play. Immediately thereafter a period of extinction of neural function supervenes [20, 37, 55] involving mainly the "higher" (suprasegmental) structures of the brain. The clinical counterparts of these "excitatory" and "paralytic" components of concussion consist of brief tonic spasm, alterations of respiratory and cardiovascular functions, temporary impairment of consciousness and loss of corneal reflexes. Mild confusion, dizziness and headache may supervene after the paralytic phase passes.*

*Refers to ischemia, hypoxia, hypoglycemia, retention of catabolites, intra-cellular fluid imbalance, acid-shift of pH, positive and negative "voltage drifts," extinction, cell membrane depolarization, dysfunction of intracellular respiratory pigment-enzyme systems and other as yet unidentified or poorly defined colloid-crystalloid relationships[12, 19, 20, 37, 49, 55].

†The present writer supposes that all gradations of intramolecular derangement from reversible to irreversible may be induced by traumatic violence and that the term "concussion" properly applies only to the quickly reversible and therefore least nocuous degrees of intramolecular derangement. On this view, the clinical diagnosis of concussion necessarily is and must remain an ex post facto affair.

*This account effectually displaces the older anemic[51, 52],

In concussion as here conceived, gross pathological changes are rarely demonstrable. Microscopic findings, although subtle, appear early (within 30 seconds) and are considered by Windle[59,60] to represent a highly characteristic form of chromatolysis. Such changes reach their maximum at 7-8 days and regress rapidly thereafter. In the more severe traumas, less readily reversible degrees of intramolecular derangement are produced and focal or diffuse microscopic hemorrhages are demonstrable within and upon the surface of the brain. These interfere with the circulation of blood and the egress of cerebrospinal fluid, the consequence of which is the cellular respiration becomes deficient and the usual perverted response of cells to anoxia is discernible, namely, the uptake of tissue fluids. Edema is the result and in its turn it mechanically comprises the vascular radicals of neighboring tissues, completing the cycle of ischemia, hypoglycemia, and anoxia. Hand in hand with these changes, a process of cellular outfall and encephalomalacia may rapidly develop so that within the first week a previously normal ventricular system may show progressive dilatation. The latter may advance for several months after clinical recovery has been established. (Figure 5)



Fig. 5. Pneumoencephalogram, antero-posterior view, after a moderately severe craniocerebral trauma, illustrating "Hydrocephalus Ex Vacuo" due to encephalomalacia and gliosis. Periodic visualization of the ventricles was begun 9 days after injury and demonstrated a progressive dilation from near-normal to the condition shown above. Compare with Fig. 6, page 324.

In virtually all instances, the clinical signs and symptoms encountered in cases of head injury are directly or indirectly ascribable to the pathologic processes catalogued above. Our endeavor to deal with the important matter of diagnosis will be advantageously served at this point by reviewing the clinical manifestations that may be subtended by such processes. These are

I. Modifications of the State of Consciousness:
  A. Psychomotor and emotional activities.
    Maniacal, Thrashing, Shouting
    Combative, Negativistic, Resistive, Spitting
    Hypomaniacal, Excitable, Delirious
    Resistive, Insomnic, Voluble
    Normal
    Apathetic, Inaccessible
    Bradykinetic, Random and Semipurposive movements
    Somnolent, Stuporous
    Comatose, Preagonal "coma vigil".
  B. Intellectual and Social Activities.
    Confusion, Disorientation, Dulled Perception
    Inappropriate Behavior
    Aphasia
    Amnesia
      a. anterograde (for events following injury)
      b. retrograde (for events just preceding injury)
    Distractibility, Inattentiveness
    Repetitiveness, Perseverativeness
    Incontinence of stool and urine

Diurnal and even hourly variations between the farthest extremes of responsiveness are not infrequently observed. Such swings should always be regarded as evidences of grave insult.

anoxic[24] and paralytic[17, 18] theories regarding which there were always serious objections. No doubt the older theories will prove to possess much merit in explaining those phenomena sequential to concussion.

II. Vegetative Disturbances:
1. Blood Pressure (normal; increased: decreased; instable)
2. Pulse Pressure (normal; instable; early, over 50; late, under 25)
3. Pulse Rate and Character (normal, bradycardic; tachycardic; instable; bounding; thready; coupled)

Respiratory Rate, Depth and Character (early, "stertorous" — slow, deep and noisy; late, rapid, shallow; inspiratory phase shorter than expiratory; mucus present or absent; hiccoughing).

5. Temperature (hyperthermia, average 101-104° F.; if uncombatted may reach 107-109° F.)
6. Upper gastro-intestinal tract (nausea, vomiting, regurgitation of bile)
7. Skin —
   (a) Anhidrosis, unless complicated by toxic or infectious processes.
   (b) Flushed or cyanotic head, neck and chest. Preagonal mottling of extremities.
   (c) Goose-flesh in decerebrate states and other severe injuries.
8. Sugar Metabolism (hyperglycemia, glycosuria)
9. Sphincters — incontinence of stool and urine

III. Somatic Neurological Manifestations:

A. General Signs.
1. Headache (its locus is not a reliable index of the site of lesion)
2. Blurred vision, photophobia
3. Internal strabismus, Diplopia, 6th Nerve palsy
4. Vertigo, Incoordination, Tinnitus
5. Epileptiform and Decerebrate seizures

B. Meningeal signs (usually due to subarachnoid blood)
1. Headache, photophobia
2. Nausea, vomiting
3. Fever (101°-103° F.)
4. Stiff neck, extensor hypertonus
5. Kernig and Brudzinski signs
6. Moderate leukocytosis

C. Focal Signs, expressed as dysfunctions of—
1. Cranial Nerves (particularly the 8th, 7th, 6th, 3d and 2d)
2. Motor power and muscle status
3. Reflexes, deep and superficial
4. Coordination, non-equilibratory and equilibratory.
5. Sensation, general and special forms, deep and superficial modalities.

Neurological signs may be conveniently thought of as subtended by *irritative* or *paralytic* lesions. The former appear as exalted or perverted functions, e.g., hypersensitivity, twitchings, and focal or generalized seizures. They commonly signify early or incomplete neural damage. The latter appear as depressed functions, e.g., hyposensitivity, dyspraxia, paresis or paralysis. They commonly signify late or complete neural damage. There is obviously much overlapping between the two.

It is particularly important that the physician evaluate the pupillary, extraocular and visual functions at frequent intervals. The side on which a lesion exists is frequently (though not invariably) betrayed by a dilatation of the ipsilateral pupil and lateral rotation of the eyeballs "toward the lesion."

Unfortunately, two circumstances not easily capable of circumvention seriously interfere with attempts to postulate pathologic lesions from clinical findings. The first is that *multiple lesions are the rule,* and its consequence is that classical clinical syndromes are frequently "masked." The second is that irrespective of the completeness with which the clinical neurological signs and symptoms are explored, the nature of the underlying pathologic process cannot be reliably inferred therefrom. This is because *neurological signs and symptoms are essentially manifestations of a disturbed physiological mechanism* and are therefore much alike, regardless of the agent which produces them. Thus, the hemiplegia resulting from a massive extradural clot cannot be readily differentiated from that resulting from cortical laceration, cerebral edema, depressed facture, intramolecular derangement, apoplectic hemorrhage, embolism, tumor, abscess or encephalitis. The *locus* of the morbid process may be reasonably inferred,* but the clinical fea-

*Even in the matter of localization, unsuspected factors may intrude and mislead clinical interpretation. For example, a large subdural clot may cover the right cerebral hemisphere without producing perceptible dysfunction of the adjacent cortex. It may nevertheless so far displace the brainstem as to cause the left peduncle to impinge against the tentorium cerebelli. The consequence may be the appearance of positive neurological signs in the limbs ipsilateral to the lesion.

tures of hemiplegia — spastic paralysis, hyperactive tendon reflexes, Babinski sign, absent abdominal reflexes, etc. — in no sense betray the pathologic nature of the lesion.

All this being generally recognized, attempts have been made to discover a correspondence between the sequential course of neurological signs and symptoms, and specific pathologic lesions. These efforts, emerging in the form of "clinical entities" and "syndromes", have met with varying degrees of success. They have been abundantly exploited in textbooks without sufficient stress being laid upon the fact that their greatest utility is in the presence of a "pure" lesion. Even under ideal circumstances they do not *make* a diagnosis; they merely indicate its probability. Their general applicability to the problem of discovering the nature of a pathologic lesion is seriously interfered with by the fact that in the majority of patients multiple rather than pure lesions prevail.

We may examine in this connection the syndrome of epidural hemorrhage, the essential features of which consist of unconsciousness from the time of injury, prevailing for a varying period (commonly 3-20 minutes) and followed by a lucid interval; thereafter, the gradual development of unilateral headache, somnolence, stupor and coma; all attended by enlargement of one pupil, conjugate deviation of the eyes toward the side of the clot, paresis and increasing spasticity of the contralateral limbs, vomiting, rise in blood pressure and fall in pulse rate. This is certainly the best known and very likely the most reliable of the traumatic syndromes. Yet every neurosurgical service can show case histories (a) in which no suspicion of the lesion ever arose clinically, the surgically-amenable lesion being disclosed (to everyone's embarrassment) at the autopsy table[54], and (b) in which the clinical syndrome appeared to be fully in evidence but in which at operation or necropsy an epidural clot was not disclosed, there being encountered instead a subdural or intracerebral clot or merely a local contusion attended by brain edema[7].

Another entity that has gained a seemingly inviolate place in the textbooks is that of "brain compression due to increased intracranial pressure". It is asserted that from the observation of a rising blood pressure, falling pulse rate, slowing of respiration and deepening stupor the clinician may reliably infer the existence, degree and progression of increased intracranial tension. It is further claimed that from these data may be derived criteria which indicate the appropriate type of therapy, whether conservative or operative. The extreme unreliability of such schemata and the serious errors that follow reposing confidence in them have been demonstrated by clinical and experimental studies[7,8,9,38] and will not be reiterated here.

Even greater uncertainty attaches to the more nebulous clinical syndromes of acute subdural hemorrhage[32], traumatic subarachnoid hemorrhage[26], etc. Recent writers have been impressed with the limitations of these concepts and have urged that good clinical judgment rather than adherence to rule-of-thumb guides constitutes the most valuable asset in caring for patients with craniocerebral trauma[9,16,21,30].

At this point of our inquiry we appear to have reached an impasse. Proper treatment, it has been asserted, depends upon proper diagnosis; and the latter consists in a process of inference by which the nature of the pathologic lesion is adduced from the clinical manifestations. But, as we have seen, the pathogenesis of neurologic manifestations is such that inferences as to the nature of the responsible pathologic agent cannot be implicitly trusted. Fortunately, there is a way of circumventing this impasse and it consists simply of recasting traditional goals in more dynamic and attainable forms. Instead of groping among a welter of clinic signs and symptoms for the stuff from which a mental image of the patient's pathologic lesion may be fashioned, the clinician is urged to set his course by the following principles: first, that no case come to autopsy with a clinically unrecognized and unoperated surgically amenable lesion; second, that the number of cases subjected to operation and proving to have a non-surgically amenable lesion be held at a minimum; and, third, that to all cases the most rational and effective therapy available in present-day medicine be administered.

A corollary to these formulations is that the clinician constantly keep before him the neces-

In actuality, the principle of contralateral representation has not been violated here, but the manner in which interpretation may be equivocated by an undemonstrable factor is clearly illustrated.

sity of deciding *whether* and *when* conservative measures should be supplemented by surgery. The lesions that commonly demand surgical attention in the early days following trauma are as follows: (1) compound fractures of the vault, with or without depression indriven, bony fragments, foreign bodies, devitalization and/or extrusion of brain tissue; (2) simple depressed fractures of the vault such that the outer table of the depressed portion is at or deeper than the inner table of the adjacent vault; (3) epidural hemorrhage; (4) subdural hemorrhage or hemohygroma; and (5) massed intracerebral and intraventricular clots. The first two of these rarely present diagnostic difficulties, being in many instances immediately apparent or at least strongly suspect from external signs alone. They are readily confirmable by x-ray. Of the last three, epidural hemorrhage is, of course, the most urgent. When their presence is conjectured, empirical procedures may be pressed into service to aid in resolving the diagnostic issues.

Upon admission, the patient is carefully examined and a "base-line" consisting of a record of the vital signs, state of responsiveness and general and neurologic examinations is established to which all future findings are referred. Definitive management now begins.

*Shock.* If shock is present, its management takes precedence over that of all other concomitant conditions. The standard measures for combatting shock are sufficiently well known to make their reiteration here unnecessary. For reasons that will be set forth below, morphine, generally considered an integral part of the treatment of shock, is contraindicated in head injuries. Similarly interdicted is the practice of lowering the head below trunk level. This posture facilitates the development of intracranial venous stasis and cerebral hypoxia.

Shock ascribable to head injury *per se* is, as a matter of record, uncommonly encountered, being present soon after admission in less than one percent of cases at Kings County Hospital. This statement should not be construed to mean that shock is rarely produced by head trauma, for it is obviously true that severe shock may kill almost instantaneously or within 10-15 minutes. It merely expresses the fact that if the initial shock produced by head trauma *per se* is not severe enough to kill quickly, it is rapidly recovered from. The result, in the vast majority of instances, is that by the time the patient reaches medical help he is either altogether out of the shock or is rallying from it. It has been our experience that among the approximately 6-8 percent of head-injured patients who upon admission present the picture of shock or develop it shortly thereafter, the great majority prove to harbor an *extracerebral* cause. The latter includes damage to the lungs, liver, spleen, adrenals, kidneys and bladder, fractures of the ribs, vertebrae, pelvis and long bones, burns, exposure to cold weather, exhaustion in hot weather, depleted nutritional states, severe alcoholic or drug intoxications, exsanguination from lacerations of the scalp, viscera or large vessels of the extremities, etc.

If active hemorrhage is present, it should be stopped by digital compression, pressure bandage, tourniquet, hemostatic clamp or mattress sutures. The neighboring parts should be shaved and the wound cleansed with some innocuous antiseptic, such as Zephiran[48]. Alcohol-containing agents may devitalize the tissues. Before closure, a few crystals of sulfanilamide may be sprinkled in and upon the wound. A dry gauze dressing is applied.

Other than active hemorrhage, the only condition that demands immediate attention is impending asphyxia and this can usually be combatted by arranging the patient in a position such that the tongue, pharyngeal secretions, blood and vomitus can gravitate away from the pharynx. The classical Shäfer resuscitation position is ideal for this purpose.

*Transportation.* Experience has established that the cranially-injured tolerate transportation well, even over distances of 50 to 150 miles. It is certainly far better to transport the patient to a hospital where the facilities for sustained observation, proper medical and nursing care and, if indicated, prompt surgical intervention are available than to retain him at the first stopping-place under the mistaken apprehension that moving him will seriously jeopardize his chances of recovery.

Once transportation has been decided upon, two practical points require consideration; first, that in being transferred between bed and stretcher, the patient should be moved smoothly and firmly in "log-fashion", the sagittal planes

of the head, shoulders and pelvis being maintained in strict alignment; second, that during the trip he be kept in the Shäfer posture.

*Position.* Upon arrival at the hospital the patient is moved to a quiet room and the head of the bed is raised about 20 degrees above the horizontal. He is placed well over on his side. Prophylaxis against hypostatic pneumonitis and decubitus is then instituted by turning the patient from side to side every two hours.

*Protection.* Confused, refractory, hyperactive and stuporous patients may imperil their welfare by climbing or falling out of bed, by removing dressings, oxygen catheters, Levine tubes, etc., and by thrashing about. Sedation in such cases may not prove wholly effective, in which event sideboards and restraints will be required. The camisole is by far the most effective and innocuous form of restraint. Somewhat less satisfactory, though usually more readily available, are leather cuffs or strong muslin bandage ties applied to the wrists and ankles. If abrasions, cyanosis and edema are to be avoided, proper underpadding and secure anchorage without slack are precautions that must be exercised. Rolled sheets are incapable of restraining vigorously active patients and if improperly applied they may choke the patient or seriously damage the large nerves and vessels in the axillae. Their use is therefore emphatically condemned.

*Vital Signs.* Readings of the blood pressure, pulse rate, respirations and temperature should be recorded every 15 minutes as long as variations of clinically significant magnitude are in evidence. If and when physiologic stabilization is established, the interval between successive readings may be increased. A pulse rate of 50 to 60 beats per minute is not uncommon after even mild head injuries and may persist for weeks. In itself it need not arouse much concern. The same may be said of a respiratory rate ranging in and about 12-14 cycles per minute. However, blood pressures above 160/100 and less than 80/50 and hourly fluctuations of blood pressure, even when they occur within these limits, constitute untoward signs. In the same manner, instability of the pulse and respiratory rates must be regarded as untoward signs. The appearance of respiratory cycles in which the rate and depth build up to a peak and then taper off every few minutes is to be looked upon as a forerunner of the Cheyne-Stokes pattern and carries a guarded prognosis.

*Pulmonary Ventilation.* An ever-present awareness of the importance of oxygen-exchange to the sustenance of neural fuction is indispensable to proper management. The neural respiratory mechanism is far more susceptible to insult than the cardiovascular[10,17,38] and it has been convincingly demonstrated that if proper respiration is maintained, the neural cardiovascular mechanism can be relied upon to carry out its functions with machine-like efficiency. As soon, however, as hypoxia is permitted to develop, untoward circulatory changes supervene, e.g., rise in blood pressure, widening of pulse pressure and bradycardia. Ultimately these break over into circulatory collapse[10]. Where oxygenation is satisfactory there is no necessity of giving pharmaceutic support to the cardiovascular system in the form of digitalis, caffein, adrenaline, ephedrine, etc.

The on-the-side and Shäfer postures recommended above greatly facilitate respiratory exchange by allowing the tongue to gravitate forward. If mucus collects in the pharynx and larnyx it is to be aspirated by a "fishing" technique through a No. 14 French catheter connected to a suction pump. Lax or edematous lips and nasal obstruction due to dried blood in the nostrils may force a patient to bring the accessory respiratory muscles into play and an oxygen debt may be slowly built up. In such cases, a metal air-way often allows prompt relaxation. By the use of this simple device the writer has often seen vegetative instabilities and neurologic dysfunctions melt away. Slight adjustments of the head on the pillow will often make the difference between effortful and relaxed breathing.

At the first sign of cyanosis, oxygen should be administered under a pressure of 7-10 liters per minute. The nasal catheter technique of administration is less cumbersome than the oxygen tent and for physiologic purposes is almost as effective.

*Neurologic Examination.* The importance of establishing a base-line of neurologic findings as soon as feasible following admission is self-evident. Subsequent developments may be advantageously measured against it and impressions may be formulated as to whether the pa-

tient is gaining or losing ground. Deepening stupor and the progressive development of pupillary disparities, squints and conjugate deviations of the eyes, aphasia, paralysis, spasticity, twitchings and convulsive phenomena constitute the chief "danger signs" from the neurological standpoint.

*X-ray Studies.* If during the first few days the patient's general and neurologic condition is satisfactory, the clinician need not be greatly exercised over resolving the question as to whether or not a skull fracture exists. Certainly the prognosis in a given case is not much modified thereby, for the patient's condition depends much less upon his skull injury than upon the concomitant cerebral damage. While it is in general true that the presence of a skull fracture is a rough quantitative index of the physical violence delivered, clinical experience bears out the significant points that (a) on occasion linear and stellate fractures may occur without the patient's being rendered unconscious and without the supervention of neurologic or psychologic dysfunction; and (b) severe and fatal brain injuries often occur without accompanying skull fractures. The therapeutic regime adopted in a given case is posited upon what is conceived to be amiss with the brain — or with what may ultimately arise therefrom (infection, cicatrices, paralyses, convulsions[43], etc.). Even when it is necessary that surgery be directed at the elevation of a depressed fracture, the removal of indriven fragments of bone, or the debridement of a compound comminuted fracture, what is done to the bone as such has little bearing on the patient's condition. This is not intended to imply that x-rays should not or need not be taken. The demonstration of depressed and indriven bone fragments, foreign bodies, compound fractures of the sinuses[47] and linear fractures across the course of the middle meningeal artery may indeed prove to be of considerable diagnostic value; and the interest of future litigation is necessarily concerned with a determination as to the existence of demonstrable fracture. Nevertheless, it is but rarely necessary to hurry the newly admitted patient to the x-ray table and in the great bulk of cases röentgen examination may well be postponed until the third or fourth day.

*Laboratory Studies.* Soon after the patient's admission, a routine urinalysis and complete blood count should be carried out. In the more severely injured cases, a blood sugar and N P N determination is desirable. Wasserman tests are routinely done in some neurosurgical clinics. In all cases in which alcoholic intoxication is under suspicion, the determination of the alcohol content of the blood should be made *early*.

*Temperature Control.* One of the conspicuous clinical features of severe brain injuries is the development of an anhidrotic fever. It is important to recognize that in and of itself this hyperthermia may kill the patient. With the sweating function in abeyance, the dissipation of heat from the body is accomplished chiefly by means of respiration and the physical mechanisms of conduction and radiation. It is understandable that at ordinary room temperatures and in hot weather the latter are not very effective, for they depend upon the existence of a steep gradient between the patient's temperature and that of his environment. Every precaution must therefore be taken to keep hyperthermia under control. The room temperature should be held at 55-60° F. Following the patient's admission, rectal temperatures are taken every two hours. Provided the successive readings are near-normal, stabilized, or falling in the direction of normal a temporizing policy may be adopted and the interval between reading may be increased. But whenever the temperature exceeds 102.5° F., active measures should be taken to combat the fever. The patient is stripped of covers and bed clothes, an electric fan is played upon his exposed body and sponging is instituted, employing a washcloth moistened in a tepid "50-50" solution of alcohol and water. This process is continued until the rectal temperature falls below 101.5° F. It is re-instituted whenever the critical level of 102.5° is exceeded. If, after an hour or so of sponging, the temperature fails to recede or if it continues to rise, a second method of attack is resorted to, namely, the colonic instillation of cool water. A necessary preliminary to this procedure is the simultaneous determination of rectal and axillary

temperatures. This permits the establishment of an "axillary-equivalent" of rectal temperature. A tube is now inserted some 18 inches into the colon and 3-5 liters of cool tap water are caused to gravitate into the large bowel. The colonic tube is then clamped off for eight minutes at the end of which period the water, by now warmed, is siphoned off and replaced by a second instillation. This process is repeated until it is estimated that the rectal temperature has fallen to 101.5° F. Meanwhile, large doses of aspirin (30-50 grains) may be administered. On occasion this drug has a highly salutary effect. Should the second line of attack fail, a final resort is made to ice-packs. The clinician must live out the conviction that in head injuries, as in heat stroke, *hyperthermia must be effectively controlled by one device or another* else the fight will be lost on this ground alone.

*Orificial Bleeding.* Bleeding and the escape of cerebrospinal fluid from the nose or ear need not excite alarm. In the majority of instances spontaneous cessation occurs within few hours or days. Operative intervention is rarely necessary during the first 3-4 days. The involved orifice may be washed or swabbed out as occasion demands, but packing, medicinal instillations and irrigations are strongly interdicted, for they may establish a pyogenic meningitis. The patient's posture should be such as to favor gravitational drainage and he is urged to suppress coughing and sneezing. Penicillin in 20,000 unit doses should be injected intramuscularly every 3 hours as a precaution against the development of meningitis, cerebritis and osteomyelitis. Should meningitis nevertheless develop, it is recommended that 10,000 units of penicillin in 10 cc. of isotonic saline be injected intraspinally once or twice daily[1,44].

*Chemotherapy, Antibiotics and Sero-Therapy.* Whenever pyogenic infection is actually or potentially present, penicillin and/or sulfonamide therapy should be administered. It is of course necessary to carry out the usual cutaneous or conjunctival tests for serum sensitivity.

*Sedation.* Stuporous and unresponsive patients require no sedation*. Restiveness should be combatted by sufficient doses to prevent the patient from injuring and exhausting himself. The following drugs, used singly or in combination and administered by mouth or rectum are strongly endorsed: phenobarbital gr. i-iii, bromides gr. xx-xl, chloral hydrate gr. xx-xxx and paraldehyde drams i-iii. Very disturbed patients require intramuscular or intravenous barbiturates, e.g., sodium amytal gr. v-xv.

It is worth bearing in mind that in the head-injured patient, a distended bladder is capable of exciting much restiveness. Catheterization offers prompt relief.

The narcotic drugs should be circumspectly avoided for the following reasons: (a) their miotic effect precludes the development of one of the most valuable of "localizing" signs, viz., a disparity in the size of the pupils; (b) they depress the activity of the respiratory and cardiovascular mechanisms, functions which may have been already embarrassed by trauma; (c) they increase intracranial tension by 50-120 mm $H_2O$, even in the normal individual; (d) they exert undesirable side-effects, e.g., on the gastrointestinal functions; and (e) as sedatives they can accomplish nothing that cannot be achieved by the use of less nocuous agents.

*Lumbar Puncture.* In the writer's opinion, diagnostic lumbar puncture may be carried out to advantage on all freshly injured patients except those with bloody or spinal fluid discharges from the orifices. In the latter, there is a possibility of reversing the pressure-gradient and of further exposing the portal to infection. The two issues under inquiry in such examination are: (a) the determination as to whether there is blood in the spinal fluid and, if so, approximately how much; and (b) the determination of the cerebrospinal fluid pressure.

Both questions can be quickly answered with the loss of but 1-2 c.c. of fluid and the information thus obtained may give the clinician a useful attitudinal "set" for the evaluation of subsequent developments. Thus, if the spinal fluid proves to be water-clear and under normal pressure, it is extremely unlikely that cerebral laceration or contusion, and subarachnoid, subdural, intracerebral or ventricular hemorrhage are present. Under these conditions, if the patient should subsequently lose ground, the suspician that he harbors an epidural clot is justified, particularly if at a second examination the spinal fluid should be again clear but under increased

*Obvious as this may seem, the principle involved is more often violated by practitioners than it is honored.

pressure. It would then become imperative to project further clinical, roentgenographic and surgical inquiries. On the other hand, if the spinal fluid on first encounter should prove to be bloody and under normal or near-normal pressure, the inference would be reasonable that cerebral contusion, laceration and subarachnoid hemorrhage exist, and very probably also subpial and petechial hemorrhages. That the preconditions for the development of edema are already present in such a case is a safe assumption. If such a patient should lose a small amount of ground, the necessity for pressing the inquiry as to the existence of a surgically amenable lesion would be less urgent than in the first case.

The present writer is not impressed that the severity of cerebral trauma can often be expressed in terms of intracranial hypertension or that the manometry of the latter can be made a valid criterion as to the mode of therapy indicated[7,8,9,38]. Nevertheless, he is disinclined to forego the acquisition of objective data so readily obtainable and is unable to concur with those who deny the value of lumbar puncture.

To obtain reliable information, manometry must be carried out with the patient in the lateral horizontal posture. The normal pressure range is 6-12 mm Hg (80-180 mm $H_2O$). In the head-injured patient, the Quekenstedt test should never be carried out. It is not only incapable of yielding information as to the presence of intracranial pathology but carries with it the danger of precipitating hemorrhage.

The therapeutic (as opposed to the diagnostic) value of lumbar puncture is a matter of controversy. Some authors contend that intracranial hypertension and cerebral edema can be successfully controlled in the majority of cases by repeated spinal taps, the quantities withdrawn ranging from 30-60 c.c. up to complete emptying[23,39,40]. They consider that repeated withdrawals serve an additional purpose in that blood is gradually eliminated from the cerebrospinal fluid. Blood, when extravasated in the subarachnoid space, is presumed to act as a meningeal irritant and to interfere with the egress of the fluid into the venous system. Other workers, however, deny that such virtues attach to therapeutic taps and warn against its potential dangers[16,29,30]. They contend that the reduction of intracranial pressure may permit recently occluded vascular channels to repoen; that it may result in herniation of the temporal lobe through the tentorium cerebelli or of the cerebellar tonsils and medulla through the foramen magnum; and that it usually excites a compensatory over-production of cerebrospinal fluid such that in 2-3 hours the intracranial tension may be higher than it would otherwise have been. They acknowledge the validity of experimental evidence[16] to the effect that blood in the subarachnoid space may impede the absorption of fluid, but they find little empirical evidence to indicate that such constitutes a clinically significant factor. They further assert that hemorrhagic processes which produce increased intracranial pressure cannot as such be favorably influenced by the withdrawal of spinal fluid and that in the presence of hemorrhagic lesions, any salutory effect that follows the tap is short-lived at best. At the same time, it is argued, the patient's margin of safety is reduced, in that "non-displaceable" elements (cerebral edema and collections of blood) are enabled to take up space previously occupied by the displaceable cerebrospinal fluid. Lastly, they insist that processes other than hemorrhagic, such as cerebral edema, which appear to be favorably influenced by repeated taps are quite as susceptible to control by other measures — posture, dehydration, etc. This is not the place to inquire into the relative merits of the arguments for and against therapeutic puncture. It appears, however, that there can be little objection to its occasional use as a stopgap measure by which may be gained a few hours' delay when needed as a preliminary to surgical intervention.

*Dehydration.* Following the demonstration in 1921 that hypertonic saline administered intravenously is capable of reducing intracranial tension[56] it became standard clinical practice to employ dehydration measures in the treatment of head injuries. In addition and directed at the same end, the patient's daily fluid intake was commonly restricted to 600-1000 cc. per day and epsom salts* were administered by mouth. Through the years, hypertonic saline has been replaced by glucose, glucose by sucrose[35] and sorbital[33], and the sugars in turn by concentrated serum[27,53]; but the principle of dehydration in

*The use of magnesium sulphate by parenteral injection was ill-conceived from the outset and its abandonment has been urged[42].

one form or another is still ardently advocated by some workers[23,39,46]. However, a serious warning of the dangers attaching to dehydration has been sounded by several investigators[4,6,26,28,29,30] who point out that following head injury intracranial hypertension of magnitude sufficient to constitute a clinically significant factor is the exception rather than the rule; and that in those cases in which it appears to be a factor, the effect of administering hypertonic solutions is not only unpredictable but may prove frankly detrimental. It has been shown that hypertonic solutions may produce renal damage and that the side-effects of water depletion[11,12], particularly in the presence of hyperthermic or toxic states (such as those imposed by infection, delirium tremens, etc.), cannot be minimized. It is further contended that "reverse osmosis" may kill. When the finer vascular radicals of the brain have been interrupted by laceration, contusion or severe "commotion," the through passage of hypertonic solutions by which it is conceived edema may be reduced, is effectively blocked; and, what is still more serious, the hypertonic agent may spill out of the injured vessels, infiltrate the interstitial tissues and further intensify the pre-existing edema.

On the whole, the principle of vigorous dehydration as applied to head injuries appears to possess little merit. The clinician may with reasonable impunity order magnesium sulphate ounces iss by mouth once or twice daily and caffeine-sodiobenzoate gr. viiss by muscle 4 to 6 times daily, but the daily fluid intake should exceed 1800-2000 cc. and in the presence of hyperthermia, delirium tremens, etc., well over 3000 cc. are required.

*Nutrition.* Unconscious and restive patients should not be carried for more than 24-48 hours on mere parenterally-administered fluids. If, at the end of this period, they are still unable to take nourishment by mouth, a Levine tube should be passed via the nose and hourly feedings instituted as follows:

First hours: ounces iv of glucose water

Second hour: ounces iv sweetened fruit juices

Third hour: ounces iv of eggnog

The sequence is repeated at the fourth, fifth and sixth hours, etc., throughout the entire 24 hours. Three grams of table salt should be added to the daily diet. The general superiority of the method of administering nutritive and medicinal agents by Levine tube over parenteral methods is obvious.

*Mouth Hygiene.* Unconscious patients, breathing for hours on end through the open mouth, are prone to develop parotitis. For this reason it is important to cleanse the mouth of dried saliva every 3-4 hours. A good solution for this purpose consists of equal parts of glycerine and lemon juice. In addition, a simple humidifier may be employed in the form of a water-moistened double layer of gauze laid across the external air passages.

*Elimination.* Urinary incontinence is the usual finding in stuporous and disturbed patients. It is essential, if the development of decubiti is to be averted, that linen be changed as soon as soiling occurs. If desired, an indwelling catheter may be passed into the bladder and either clamped off or led into a bottle beneath the bed. In the former case, the clamp should be released every 4-6 hours. Urinary retention is much less frequently encountered than incontinence but when present it may be managed in a similar fashion. The bladder should be periodically irrigated with a mild antisceptic solution every 4-6 hours and the catheter should be changed every few days.

During the first 2-3 days following head injury, little attention need be given the bowels. Incontinence of stool does occur but it is not nearly as frequent as urinary incontinence. When magnesium sulphate is in use, incontinence is more likely to appear. Fecal impactions are prone to develop in unconscious patients and should be sought whenever abdominal distension appears and whenever constipation is suspected.

*Convulsive Seizures.* Although dramatic, convulsions do not in themselves necessarily constitute a serious prognostic sign. This statement holds particularly true in regard to children and in respect to isolated as opposed to repeated seizures. Once it has gotten under way a convulsion cannot be readily aborted — nor need it be. The only procedures immediately necessary are those concerned with protecting the patient from asphyxia and self-injury. There is no necessity of prying the jaws apart in order to gag a mouth that is already clenched in spasm. Injury to the lips, tongue and teeth may result from such efforts. Repeated convulsive attacks



Fig. 6. Ventriculogram, antero-posterior view, illustrating normal size and shape of the two lateral and third ventricles.

(status epilepticus), however, demand active anticonvulsant measures in the form of bromides or dilantin-sodium by mouth, the barbiturates by vein or muscle, ether by inhalation, or avertin by rectum. Patients become rapidly exhausted from successive seizures.

It is important that the observer record accurately the march of motor events by which the onset of the witnessed convulsive attack was characterized. Such data may give a valuable clue as to the locus of the epileptogenic "firing point" in the brain and this in turn may influence surgical therapy.

*The Indications for Surgery.* If, as an incident to the conservative regime above outlined, the patient appears to "hold his own" or actually to improve, the regime is continued. But if he shows (a) evidence of increasing stupor, (b) persistent trends of the vital sign *away from* normal ranges or frequent fluctuations as heretofore described *within* normal and near-normal ranges, and/or (c) progressive neurologic dysfunction, he should be seriously suspected of harboring a surgically amenable lesion.

The question thus raised can be answered with fair certainty by the placement of burr openings over both parietal regions. Should an epidural or subdural clot be disclosed through these openings, it may be evacuated by whatever technique seems most applicable to the case in hand. Should neither of these lesions be disclosed, it is not defensible to conclude that no surgically-amenable lesion obtains. Acting in accord with the concept that a surgically-amenable lesion, if present, will betray itself by displacing or distorting the cerebral ventricles, ventriculography is now resorted to. If the ventricular shadows appear essentially normal the reasonable conclusion is that a surgical attack is not warranted (Figure 6.). In this case, the conservative measures previously employed are re-instituted. The demonstration of a ventricular shift or distortion, however, constitutes clear indication for the reflection of a bone flap and a thorough search for an epidural, subdural, intracerebral and intraventricular clot (Figure 7.). If such a lesion is encountered, it is evacuated; if none is found, the reasonable inference may be drawn that the ventricular shift or distortion must have been subtended by focal edema. In the latter case, the bone flap may be sacrificed or loosely replaced. It must be said that non-specific "decompressive" procedures of the latter type can rarely be relied upon to serve their intended role.

A practical word of caution to the surgeon is offered here: if a considerable ventricular shift has been demonstrated roentgenographically and at operation a subdural clot, too thin to account for the degree of shift, is encountered, his responsibility is not properly discharged by mere evacuation of the subdural clot. He is obliged in such cases to incise the cortex over one or more silent areas, thus to prove whether the shift is due in part to an intracerebral clot. Sounding with a ventricular needle is not an effective method of subcortical exploration.

Upon return of the patient to his room, conservative measures are again employed as in the period prior to operation.

Adherence to these broad general principles requires the implicit adoption by the clinician of a self-critical agnosticism concerning his ability to spot the trouble in any given case. The exercise of such clinical habits and attitudinal sets is likely to prove of greater value than reliance upon rules-of-thumb. It possesses the ad-

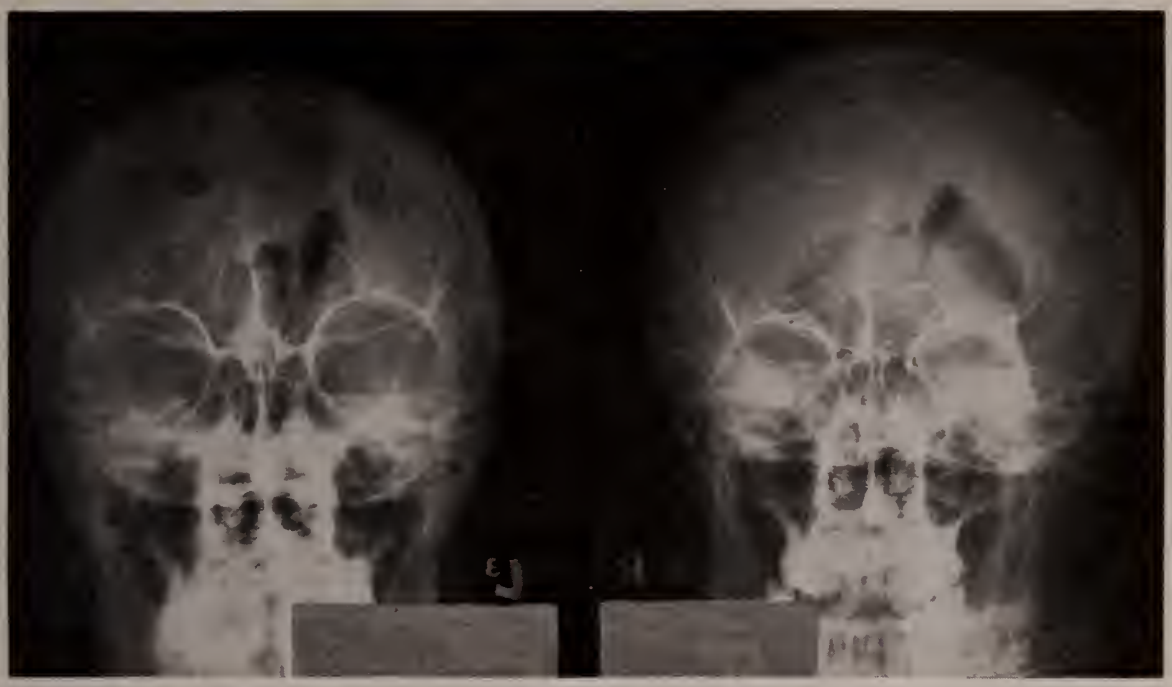


Fig. 7. Ventriculograms, antero-posterior and postero-anterior views, of patient in whom a marked shift and distortion of ventricles was produced by subdural and intracerebral clots of right hemisphere.

ditional virtues of keeping the clinician alert to the necessity of acquiring ever more information concerning the case at hand and of enabling him readily to incorporate the results of new investigations into his schemes of action.

Paradoxical as it may seem, a kind of confidence develops side by side with the practice of this brand of agnosticism — a confidence that stems from the realization that by one means or another the appropriate mode of therapy, whether conservative or surgical, can and will be made available to each patient.

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# AN ANALYSIS OF HERNIAS AND INGUINAL PATHOLOGY IN YOUNG ARMY PERSONNEL

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A review of hernias as contacted in a group of healthy young individuals, entering the army, reveals some very interesting information. This study was made on a group of cadets, entering the Army Air Corps, at the Nashville Classification Centre, Nashville, Tennessee.

This survey was made over a relatively short period of time contacting two hundred and twenty-two hernias from a group of seventy-two thousand, two hundred and twenty-eight applicants to the United States Army Air Forces, many of whom were perfectly aware of their disability but probably an almost equal number of whom were entirely ignorant of the presence of any inguinal pathological condition.

This analysis is made with special reference to:

(1) The incidence of hernias in healthy young American adults.
(2) The type of hernia.
(3) Complicating factors, associated with hernias.
(4) Suture materials used in our herniorrhaphies.
(5) Their postoperative care as regards physical confinement.

A much larger survey might have been carried out, but I feel it would reveal approximately the same analytical figures. There are no femoral hernias reported in this series, but two appeared for surgery a few days after termination of this study which were not included.

Hernia is a disease that has been recognized and treated ever since primitive man, although very little was understood about it at that time. It has been treated by diets, supports, massage and astringent plasters in the unstrangulated, and by ice packs, Trendelenberg position and taxis in the strangulated.

With the accumulation of greater knowledge of hernias, from the anatomical and etiological standpoint, various operative procedures were devised. It is interesting that the writings of Celsus in the first century A.D. mentioned the importance of excising the hernial sac, and closing the peritoneal opening. Galen in the second century discussed indirect inguinal hernia as a rupture through the peritoneum. His understanding of hernias was somewhat erroneous, as all his studies were made on monkeys, who have persistently patent tunica vaginali, and he assumed man's anatomy was similar. Russell and Sacks state that ten to twenty-nine per cent of males go through life with a patent funicular process. From the second to the fourteenth century, there was very little surgical advancement, as most of the hernias were treated by the priests, barbers and so-called hernialists. In the seventeenth and eighteenth centuries, there were extensive writings on the surgical approach to various types of hernias. In 1883 Bassini described his operative procedure, which he later modified, and many others have modified since. He stressed the importance of his first suture, biting through the so-called conjoined tendon, but especially the transversalis fascia, which actually forms the internal ring proper. Halstead in 1889 and Andrews in 1895 made valuable contributions. Modifications of their techniques are still in common practice, and actually very little advancement in the surgical approach of hernioplasty has been developed since.

Every operator finds himself becoming more proficient and obtaining a higher percentage of cures by a repetition of the procedure most familiar to him, and this explains why we have advocates of various techniques. Any of the commonly used operations give excellent results, provided a few simple rules are observed, namely: 1. High ligation to the sac; 2. Restoration of the floor of the inguinal canal. Hernial operations in the past have been devised, both to repair a defect in the peritoneal surface, and also to truss and support a supposedly weakened musculature in the abdominal wall. The correction of the first of these is most essential, but the second procedure arouses much argument these days. As mentioned previously, Bassini stressed the importance of his first muscular suture including the transversalis fascia along with the internal oblique and transversus, and this at the present day is considered one of the most essential steps to giving the inguinal wall its necessary strength. In some of our larger hospitals, no attempt is made to secure the internal oblique and transversus muscles to the reflection of Poupart's ligament, with a negligi-

ble recurrence rate. We have all had the opportunity to study how inadequate the approximation of the conjoined tendon to Poupart's ligament has been, holding in some areas and pulling away in others. This can probably be explained by the fact that tension sutures in muscle soon cause necrosis, allowing the muscle to separate from Poupart's, and it has been shown that a small percentage of people have tendinous fibres in the conjoined tendon. Many operators have reported excellent results with few recurrences by using living fascial grafts of fascia lata or fascial laces from the incised external oblique fascia, but we have many equally as good series eliminating the living graft.

It would seem that the natural physiology of these structures is very proficient at closing this area. The conjoined tendon acts as a protective shutter, when extensive strain is thrown on the abdominal wall, as lifting, or even when the abdominal muscles are voluntarily contracted. With the normal descent of this muscle as the protective demand is placed upon it, it is probably unnecessary to suture it to Poupart's ligament. It is reasonable to understand, however, that this area may be left unprotected when the conjoined tendon is caught off guard, on sudden movement or straining.

In this small series studied, a classical type of operation as described by Bassini was carried out on all our inguinal hernias with excellent postoperative result. This being a classification centre, our patients were rather rapidly transferred to other posts and we lost contact with them. However, by double checks, first by the surgeon, who operated on them six weeks previously, and second by the re-check department of the classification centre, eight weeks postoperatively there were no recurrences. With satisfactory results at eight weeks, I feel we have reason to assume that certainly the majority of our hernias remained cured.

A review of the incidence and type of hernias in this group of young men reveals some interesting figures. In the brief period of this study, seventy-two thousand, two hundred and twenty-eight cadets were classified, and from this group, two hundred and twenty-two hernias of all types were discovered. I think we must remember that this cannot be assumed to represent a cross-section of the percentage of hernias in all army inductees, but merely a group of cadets, with ages varying from seventeen to tweny-six years. As a college education was demanded at this time for eligibility for the air corps, this group probably was drawn from a higher social strata than average in which many anatomical defects had been previously corrected surgically.

Of these two hundred and twenty-two hernias, by far the largest percentage were inguinal, and the majority of these indirect. The following table shows the numbers and percentage numbers of each type of hernia discovered, and any associated inguinal pathology.

TABLE 1

NUMBER OF CADETS EXAMINED 72,228

| | Number | Percentage |
|---|---|---|
| Cadets with Hernias | 222 | 0.307 |
| Cadets with Direct Inguinal Hernia | 3 | 0.004 |
| Cadets with Indirect Inguinal Hernias | 180 | 0.249 |
| Cadets with Hernias & Cryptorchidism | 14 | 0.019 |
| Cadets with Hernia and Hydroceles | 6 | 0.008 |
| Cadets with Incisional Hernias | 12 | 0.016 |
| Cadets with Umbilical Hernias | 3 | 0.004 |
| Cadets with Epigastric Hernias | 2 | 0.003 |

In World War I, over two percent of the men were found to have inguinal hernias.

The type of hernias encountered represent most of the ordinary hernias seen in all age groups, except no intra-abdominal, sliding, or femoral types appear in this report.

There was a great preponderance of the inguinal type of hernia in our cadet series and naturally in a series of this decade, most of these were indirect. Usual statistics show eighty-two percent of abdominal hernias are inguinal. It is estimated that twenty-five percent of these eventually become bilateral. Only, a unilateral operation was performed unless a definite weakness was found on the opposite side. Right hernias were found much more frequently than left, in the ratio 4:3. The accompanying table 2 shows the locations and percentages of the indirect inguinal hernias.

TABLE 2

| | Right | Left | Bilateral | Total Indirect |
|---|---|---|---|---|
| No. | 84 | 64 | 32 | 180 |
| % | 46.7 | 35.5 | 17.7 | |

Direct hernias in this series are extremely rare, as would be expected in this age group,

only three being contacted in two hundred and twenty-two total hernias.

TABLE 3

| | Right | Left | Bilateral | Total |
|---|---|---|---|---|
| No. | 2 | 1 | 0 | 3 |
| % | 66.6 | 33.3 | 0 | |

As found in the indirect type, the incidence of direct hernia is much more prevalent on the right side than the left, although no definite conclusions can be drawn from these few cases.

Hydrocele is frequently associated with hernia. due to failure of proper closure of the processus vaginalis, and we have a large number in our surgical records. It is difficult to report on the accurate frequency and location of these according to their anatomical location, due to the diverging reports by the various surgeons. Some reported preoperatively, were found to be due to incarcerated omentum and probably could have been reduced in proper posture. True loculated hydrocele, however, whether of the cord or scrotum, was comparatively rare. Actual cases found complicating inguinal hernia were:

TABLE 4

| | Right | Left | Total |
|---|---|---|---|
| No. of hernias complicated by hydrocele | 2 | 4 | 6 |
| Percentage of hernias complicated by hydrocele | 0.9% | 1.8% | 2.7% |

Hernia complicated by cryptorchidism is quite rare, especially after puberty, but conversely, practically all cryptorchidism is associated with a congenital type of hernia, or hernia into the tunica vaginalis. The related frequency of this condition varies with the decade of the individual. There is some statistical variance but in the first year of life, it has been reported to occur in as high as fourteen percent of children. However, spontaneous descent takes place in most instances and in the past few years, our literature has been flooded with favorable reports from endocrine therapy. From these reports I feel we have some evidence that we get an earlier descent of the testicle than otherwise might be expected, provided there is no mechanical obstruction. In adult life cryptorchidism has been variously estimated to occur in 0.1 to 0.2% of males.

In our operative work at this hospital, all cryptorchidism was treated: 1. because of the unfavorable results of parachute straps being pulled tightly around the thighs and groin and 2. because of the advantageous scrotal housing, with its excellent thermoregulation. In each case an attempt was made to lengthen the cord using the method described by Bevan and in some instances the testicle was anchored to the bottom of the scrotum or by modified Torek. In a few instances, where the cord was too short or the testicle showed too much atrophy, orchidectomy was performed.

The following table 5 lists our hernias, with, and without associated cryptorchidism.

TABLE 5

| Indirect Inguinal Hernia with Cryptorchidism | Right | Left | Total |
|---|---|---|---|
| Number | 7 | 7 | 14 |
| % occurrence in total hernias | 3.15% | 3.15% | 6.3% |

A discussion of incisional hernia is unnecessary in a paper of this type and the occurence of such is rather infrequent, as shown in the following table 6. It is interesting to note in these healthy young cadets, that their hernias were not giving them any symptoms, many of whom did not realize that they had such an affliction, and I don't believe any of them contemplated any surgical intervention. Realizing the possibility of their developing complications with advancing years, their military examination and treatment has afforded them a great service. Statistics show eight percent of hernias are incisional.

TABLE 6

| Occurrence of Incisional Hernias | Right | Left | Midline |
|---|---|---|---|
| Number (appendical) | 12 | 0 | 0 |
| % of total hernia found | 5 | 0 | 0 |

A few umbilical and epigastric hernias were found in routine examination. None of them were large and none were causing any symptoms. They were repaired in the usual manner. See table 7 showing occurrence rate.

TABLE 7

| | Umbilical | Epigastric |
|---|---|---|
| Number | 3 | 2 |
| %of Total Hernias Found | 1.3% | 0.9% |

In all our herniorrhaphies, standard cotton suture material[1] was used throughout. Spool cotton, as described by Ginkovskey in 1936, and later by Ochsner,[2] was utilized. Number 20 crochet cotton was used for ligation and transfixation of the sac, and also interruptedly to

approximate the conjoined tendon to Poupart's ligament. Number 40 cotton interrupted sutures were used to approximate the two edges of the external oblique and likewise for Scarpa's fascia. The skin was closed with a few interrupted sutures of number 10 crochet cotton. All bleeding was controlled with No. 60 cotton ligatures. With the exception of three cases in which a continuous cotton suture was used to close the aponeurosis of the external oblique, we had no wound infections and no unusual tissue reaction to suture material. These few complications merely stress the importance of interrupting all nonabsorbable suture materials.

It is quite absurd to stress the superiority of one suture material over another, as regards end results, when you study the excellent reports on the many various suture materials used in different clinics.

However, I think it is very timely to emphasize the excellent results obtained by cotton sutures, and the minimum amount of tissue reaction to it. Meade and Long's experimental studies, revealed its tensile strength, friction coefficient, heat and moisture stability and slight tissue reaction.[3]

By the use of nonabsorbable suture material, and knowing that each suture is tied individually, I think both the patient and the surgeon have a sense of great security. All our patients were allowed to get up on the second or third postoperative day, and their moderate activity judged by their own ability and discretion. They were not permitted, however, to do any of the ward work, or take any long walks until the end of the second postoperative week. By this time the wound seemed thoroughly healed, and the patients' soreness, stiffness and weakness practically gone. They now commenced to do light ward work, and engaged in the routine physical training program of the convalescent wards. Early postoperative rising was recommended as early as 1899, but the practice was not generally accepted until about the last five years.

Several recent articles have stressed the abuse of prolonged bed rest.

In civilian life, the economic aspect of early postoperative ambulation should certainly be kept in mind, due to the great shortage of hospital accommodations and the curtailment of the patient's expenses.

The normal body functions are maintained and scarcely altered as mentioned by D'Ingianni.[4]

I feel that morbidity, skeletal and vascular complications are very greatly minimized.[5] It must be remembered that many vascular accidents still occur, but due to the muscular massaging and deep breathing, certainly the circulation is improved in the peripheral, pulmonary and hepatic circulations. Abdominal distention, the so-called "gas pains", nausea and vomiting, and urinary retention have practically disappeared with early activity.[6]

Although our series is confined to indivduals in the second and third decades, there seems to be no contra-indication to the early ambulation of older people from the standpoint of wound healing or general complications.[7]

This paper represents quite a limited series of cases, but having worked on the same service for several more months, I feel it represents a quite typical and average cross-section of the youth between the ages of eighteen years and twenty-six years, entering the army air forces.

## SUMMARY

1. Author indicates the percentage of hernias and their types as found in this youthful group and the inguinal pathology associated with hernias.

2. The use of nonabsorbable suture material in the repair of hernias, with its advantages, and the absence of any disadvantages.

3. The early rehabilitation of all of these patients with excellent results and with no recurrences to our knowledge. Shortly after this series, we adopted the policy of keeping our patients in bed for two weeks postoperatively, with no better results and much increased morbidity.

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# ARREST OF ACUTE HEMOLYTIC STREPTOCOCCAL ENDOCARDITIS WITH PENICILLIN THERAPY

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The prognosis of bacterial endocarditis has been changed completely by the advent of penicillin therapy and the demonstration of its usefulness in the treatment of this serious disease. Loewe, Rosenblatt, Greene and Russell[1], MacNeal, Bleven and Poindexter[2], Paullin and McLoughlin[3], and Meads, Harris and Finland[4], have reported arrest of subacute bacterial endocarditis with penicillin therapy. Anderson and Keefer[5] state that arrest of this type of endocarditis is obtained in approximately 75 per cent of the cases treated with penicillin.

However, reports of the results of penicillin therapy in acute bacterial endocarditis have been less frequent and in general less encouraging. There have been reported 48 cases of acute bacterial endocarditis treated with penicillin[1], [4], [6], [7], [8], [9], [10], [11], [12], [13], [14], [15], [16]. Only seven of these patients recovered: in one the disease was due to staphylococcus, in four pneumococcus, and in two hemolytic streptococcus. Of the total 48 cases 25 were caused by staphylococci, 17 by pneumococci, one by gonococci, three by hemolytic streptococci, one by Brucella abortus, and in one the organism was not given. Many of these cases were treated in the early days of penicillin therapy when adequate amounts of penicillin were not available and the results can hardly be considered failures of penicillin therapy.

In a recent report, Meads, Harris, and Finland[4], present their results in seven cases of acute endocarditis treated with more adequate amounts of penicillin. There was apparent complete recovery in three cases: two pneumococcal and one hemolytic streptococcal. Of particular interest to us is the case of streptococcal endocarditis. This occurred in a 34 year old woman with a Group A, type 28, hemolytic streptococcal endocarditis of the aortic valve. There was no response to sulfamerazine. Congestive failure developed before penicillin was started and became more severe during three days of intravenous infusion of penicillin. Treatment was then changed to intramuscular injections. On the fifth day of penicillin therapy an aortic diastolic murmur appeared. The patient improved steadily on penicillin therapy. The heart recovered compensation and she is now able to carry on her usual activities. A total of 1,455,000 units of penicillin was used over a molytic streptococcal endocarditis was treated period of 16 days. A second patient with he- without success. However, only two injections of penicillin were given before death.

Loewe, Rosenblatt, Greene, and Russell[1], reported arrest in one patient with a hemolytic streptococcal endocarditis. They used a total of 1,400,000 units of penicillin over a period of 13 days. This patient had an old rheumatic valve lesion and was almost moribund when penicillin therapy was begun. We are reporting a third case of arrest of acute hemolytic streptococcal endocarditis treated with penicillin.

## CASE REPORT

Mrs. G. L. M., a 53 year old housewife, was admitted to the hospital 14 April 1945, complaining of vomiting, pain in the left foot, both ankles and shoulders, chills, and fever.

The family history was irrelevant. She was married but separated from her husband. She had three children living and well.

She denied any previous serious illness. She admitted having recurrent joint pains for several years particularly of the shoulders but at no time were they severe or incapacitating. Seven years before she had sustained a fracture of the left ankle. She had gradually diminishing hearing in both ears for ten years.

The patient was first seen in the home of her soldier son the afternoon of hospital admission. Ten days previously she had departed by motor bus from Spokane, Washington, with her son's two-year-old child. While on the bus she became ill with what she described as a "cold". She had several vomiting attacks and noticed considerable thirst. After her arrival in Madison she remained in bed several days. Her son had been confined to his home, ill with acute tonsillitis for several days before her arrival. After three days she felt much better and was able to be up and about the home. Five days after arriving in Madison she again became ill with nausea, vomiting, chills, fever, and severe pain in the left ankle. The

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following day she had pain in the wrists, shoulders, and ankles.

On examination in the home the patient was obviously acutely ill. There were a few crepitant rales at the right lung base. No cardiac murmurs were noted. A tentative diagnosis of pneumonia was made and the patient was immediately hospitalized.

Physical examination on admission showed an acutely ill, white female, dehydrated, with a temperature of 104.4° F, pulse 112, and respirations 28. She was disoriented and answered questions with difficulty. The pupils reacted to light. No conjunctival petechiae were seen. The nose and throat were not remarkable. The neck was normal, no rigidity was present. The heart was not enlarged. The rhythm was regular, the tones of good quality. Over the entire precordium was a blowing systolic murmur. No diastolic murmurs were heard. The blood pressure was 100 systolic, 70 diastolic. There were a few crepitant rales over the right lower lung posteriorly. The abdomen was nontender. The liver, spleen, and kidneys were not palpable. The left foot was swollen, red, tender, and showed considerable pitting edema. There was only slight pretibial pitting bilaterally. Pain and tenderness were present in both shoulders. No petechiae were visible in the skin.

Portable x-ray examination of the chest on admission showed no pneumonic infiltration. The heart appeared normal in size and shape.

Examination of the blood on admission showed a hemoglobin of 71 per cent (photoelectric), red cell count of 4,020,000 and a white cell count of 13,000, with 89 per cent neutrophiles and 11 per cent lymphocytes. The urine was acid, specific gravity 1.018, albumen two plus, and sugar negative. The sediment showed 10 W.B.C.'s per HPF. The blood Kahn was negative.

Three hours after the admission examination the same examiner noted that the cardiac murmur was definitely louder and rougher with no change in pulse rate or the condition of the patient. The following morning her temperature was 101°. She was unable to realize that she was in a hospital or to give the correct day or month. Her story of her illness was incoherent. Examination showed no neck stiffness. Both pupils reacted to light. There was one small questionable petechiae in the right conjunctiva. Over the anterior chest were several 3 mm. sized red lesions suggesting petechiae. The blood pressure was 94/64 mm. of mercury. The heart was regular, rapid, with tones of fair quality. The left border of percussion dullness was at the mid-clavicular line in the 5th interspace. Over the whole precordium was a long, harsh, systolic murmur. At the apex and toward the left sternal border it was of grade three intensity and at the base grade two intensity. The murmur was heard in the axilla, at the left lung base posteriorly, and in the neck. No diastolic murmurs were heard. The liver and spleen were not palpable. The left foot was still red, hot, tender, and swollen. Pitting edema was present over this foot. The peripheral pulses were palpable and normal. On the left heel was a one-inch, black, firm area with some surrounding redness.

Because of the mental symptoms a lumbar puncture was done. Initial pressure was 170 mm. of water. The dynamics were normal. The fluid was clear and showed 166 W.B.C.'s with 80 per cent neutrophiles and 20 per cent lymphocytes; 110 mg. of sugar per cc.; 20.5 mg. of protein; Wasserman negative. Cultures of the fluid showed no growth.

Examination of the blood the day after admission showed a hemoglobin of 80 per cent, red cell count of 4,110,000 and a white cell count of 20,300 with 94 per cent neutrophiles and 6 per cent lymphocytes. Urine examination was unchanged except for three plus albumen. The blood non-protein nitrogen was 57 mg. per cent, blood sugar 194 mg. Electrocardiogram showed a sinus tachycardia with a rate of 130. The P-R interval was 0.16 sec. with normal axis deviation and upright T waves.

Blood cultures taken the evening of admission and the following afternoon both showed Group A, type 17 hemolytic streptococci. Throat cultures taken the day after admission also showed Group A, type 17 hemolytic streptococci. In vitro resistance tests carried out by Major F. S. Coombs showed the organism isolated from the blood to be highly resistant to sulfadiazine and moderately resistant to penicillin. Growth by Cooke's method[17] was restricted by penicillin levels up to 0.07 units per cc. Blood cultures taken on the 3rd, 9th, 17th, 38th, 83rd, and 113th hospital days showed no growth.

Because of the persistent shock with low blood pressure and dehydration, 2000 cc. of saline and 500 cc. of plasma were given intravenously. Rapid digitalization was carried out the evening of the 2nd hospital day and digitalis was continued in maintenance doses for 14 days and then omitted. At 7:00 A.M. of the 3rd hospital day the pulse was found to be grossly irregular. An electrocardiogram showed auricular fibrillation with a rate of 130. Three hours later the rate was regular and continued so throughout her stay.

On April 15, twenty-five hours after admission, penicillin was started in doses of 40,000 units every three hours intramuscularly, 320,000 units per day. It was felt that the patient had a septicemia. The changing heart murmur, petechiae, and cerebral emboli, as manifested by the delirium and spinal fluid findings, indicated that a diagnosis of acute endocarditis was probable.

The blood pressure during the second day in the hospital varied between systolic 75 to 85 and diastolic 60 to 65 mm. The pulse varied between 120 and 140 and the respirations rose to as high as 40 per minute. The temperature rose to 105.2° R at 4:00 P.M. and dropped to 99.8° R at midnight.

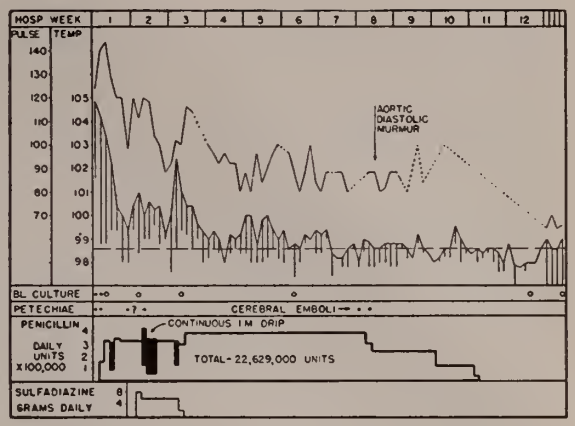
On the third hospital day she was quite alert and cheerful but continued to run a septic type of temperature to 104.6° R and pulse rate to 140. A second lumbar puncture was done which showed an initial spinal fluid pressure of 255 mm. of water. The fluid

was clear but showed 178 W. B. C. per c. mm. with 110 mg. of sugar and 20 mg. of protein. Culture of this fluid again showed no growth. The urine showed only a one plus test for albumen. The red cell count had dropped to 3,190,000 with 65 per cent hemoglobin and 10,900 leucocytes with 79 per cent neutrophiles. Blood non-protein nitrogen was 36 mg.; blood chlorides 95.5 milliequivalents per liter; total protein 8.55 gm. A transfusion of 300 cc. of citrated blood was given late in the afternoon and again the following day. The blood pressure remained at 80 to 90 systolic and 60 to 65 diastolic. A blood culture taken on the third day, after 17 hours of penicillin therapy, 240,000 units, showed no growth.

The hospital course and penicillin dosage are summarized in the graphic chart. By the fifth day there was definite improvement. On the seventh hospital day there appeared in the left groin, extending down on the buttock, clusters of red, pin head sized petechiae. A similar area was present over the left elbow. There was fluid in the left suprapatellar bursa and tenderness in both knees. On the tenth day new petechiae were noted over the chest and upper arms. The systolic murmur had become more harsh and loud. No diastolic murmurs or palpable thrills were present. Portable x-ray examination of the chest showed no abnormality in the lungs. A six foot study of the heart, patient sitting erect, showed a transverse diameter of 13.9 cm. compared with a predicted diameter of 12.6 cm. (Ungerleider and Clark). On the ninth day sulfadiazine was started in full doses and continued for nine days with no perceptible effect on the course of the disease.

Penicillin was given by constant intramuscular drip for several days but because of local reaction in the thighs and elevation of the temperature intermittent intramuscular injections were resumed. On the 17th hospital day the dose of penicillin was changed to 33,000 units every two hours, day and night.

During this whole period the patient had continued to have pains in multiple joints including the wrists, fingers, elbows, shoulders, hips and knees. The left foot slowly lost the redness and tenderness but the edema remained though diminished in amount. Surgical and orthopedic consultants failed to find evidence of purulent bone or joint infection or thrombophlebitis. X-ray examination of the left ankle and foot on the 5th and 19th hospital days failed to show any evidence of osteomyelitis or other destructive process. On the 15th hospital day there was peeling of the skin of the fingers and several days later both feet showed a similar peeling. The fingers now showed fusiform swelling and the skin had taken on a shiny appearance. There had been rapid atrophy of the small muscles of the hand with early ulnar deviation of the hand and inability to extend the fingers completely. Only slight flexion was possible. The appearance was that of a typical acute rheumatoid arthritis. During this time there was also limitation of abduction of the arms, and stiffness and pain in the knees and ankles. The calf muscles showed marked loss of substance. A moderate secondary anemia was present. Blood transfusions were




given on the 19th and on the 45th and 46th hospital days.

On the 48th hospital day a definite palpable systolic thrill was felt over the aortic area. No diastolic murmur was heard but the systolic murmur had increased in harshness and volume and was heard over the whole precordium, in the axilla, the back, and over the vessels of the neck. An electrocardiogram showed a sinus rhythm with a rate of 80, P-R interval 0.20 seconds, and moderate left axis deviation with upright T waves. Fluoroscopic examination of the heart by Captain Arnold L. Bachman on the 52nd hospital day showed the heart to be normal in size, shape, and position. The left auricle, studied with a barium filled esophagus, was within normal limits. The ascending aorta was slightly widened both to the right and left and showed moderately accentuated pulsation. The findings were indicative of a mild aneurysmal dilatation of the ascending aorta. Ill defined pulsating calcifications were seen in the cardiac shadow but because of the patient's condition they could not be carefully localized.

On the 53rd hospital day the penicillin was reduced to 240,000 units per day. The temperature had remained normal for several days with several weeks preceding of only small daily rises to 99.5° or 100°. The general improvement was marked but the swelling and tenderness of the fingers, wrists, elbows, shoulders, and knees were unchanged.

On the 50th hospital day on sitting up suddenly she became dizzy and nauseated, complained of slight pain in the back of the head, and broke out in a cold sweat. She recovered quickly. No new physical signs were found on examination and there was no rise in temperature. The blood pressure was 120/70 mm. On the 52nd hospital day while lying in bed she suddenly experienced a second attack of vertigo with double vision and a sharp occipital headache. There was no rise in temperature. The symptoms passed away within two hours and she felt well the next morning. Examination at that time showed the left biceps and triceps reflexes more active than the right. There were no changes in the reflexes of the legs and no

Babinski reflex. Examination of the heart showed a soft, short, aortic diastolic murmur along the left sternal border coming immediately after the aortic second sound. This murmur had not been present previously. With the preceding embolic episode it was interpreted as indicating the rupture of an aortic valve cusp due to the detachment of a vegetation. There was no change in the systolic murmur or systolic aortic thrill. During the next few weeks the diastolic murmur increased markedly in volume and duration and could be heard over a wider area. On the 59th hospital day an electrocardiogram showed a rate of 65, and a P-R interval of 0.24 seconds. There was left axis deviation with upright T waves. Six days later the P-R interval was 0.20 with a heart rate of 70.

On the 67th hospital day the penicillin was reduced to 120,000 units a day, and on the 74th hospital day penicillin was stopped entirely. At this time she had had a normal temperature for four weeks. The erythrocyte sedimentation rate dropped from 150 mm. per hour on the 24th hospital day to 65 mm. per hour on the 46th day. An antistreptolysin titer was 2,000 units per cc. on the 20th hospital day.

During the last month in the hospital she gained rapidly in weight and strength. Physiotherapy and the cooperation of the patient brought about marked changes in the arthritis. On the 113th hospital day she was discharged home for further convalescence. Cardiac examination still showed a grade three systolic murmur over the whole precordium with a palpable systolic thrill at the aortic area. The blowing diastolic murmur was heard best at the left sternal border, in the 4th and 5th interspaces, but was audible at the apex and base. The aortic second sound was distinctly audible. Blood pressure was 120/62 mm. Fluoroscopic examination on the day of discharge showed the heart to be normal in size, shape, and position. There was minimal rounding of the left ventricular contour. Within the cardiac shadow, in the region of the aortic valve, were seen two faintly dense irregular calcific shadows adjacent to each other pulsating synchronously with the heart beat. The ascending aorta was distinctly widened up to the region of the arch. The findings indicated calcification of the aortic valve. Laboratory examination showed a red cell count of 3,960,000 with a hemoglobin of 77 per cent. The sedimentation rate was 79 mm. per hour (Westergren). An electrocardiogram showed sinus rhythm with a rate of 65, a P-R interval of 0.22 seconds, and moderate left axis deviation with the T waves upright.

She was examined in the outpatient clinic four and one-half and again five months after the onset of her illness. There was marked improvement in the rheumatoid arthritis but she still had pains in her hips and knees and fingers. The fingers could not be completely flexed and there was still minimal swelling. The skin was soft but had lost the shiny, thin appearance. She had some limitation of motion of the hips. She denied any suggestion of dyspnea at rest or on exertion. She had walked as much as 12 blocks, up a moderate incline, with no difficulty except for her arthritis. Cardiac examination showed the same harsh, long, grade three systolic murmur over the whole precordium with a palpable systolic thrill at the aortic area. A loud, long, diastolic murmur was heard at the aortic area, along the left sternal border, and at the apex. The blood pressure was 140/69 mm. The liver and spleen were not palpable and there was no peripheral edema. The erythrocyte sedimentation rate was 41 mm. per hour (Westergren). The red cell count was 3,610,000 with a hemoglobin of 74 per cent and a leucocyte count of 6,600. The hemotocrit was 39 per cent. The urine examination was entirely normal. The antistreptolysin titer had dropped to 166 units per cc. X-ray examination of the heart showed no change from the previous examination. An electrocardiogram showed a sinus rhythm with a rate of 120. The P-R interval was 0.15 seconds and there was moderate left axis deviation with upright T waves. The patient was making plans to leave for her home in Washington the following day.

Final Diagnoses: Acute bacterial endocarditis of the aortic valve, due to Group A, type 17, hemolytic streptococci; aortic stenosis and insufficiency; rupture of aortic valve due to bacterial endocarditis; sclerosis of aortic valve; acute rheumatoid arthritis.

## DISCUSSION

During the course of the illness a diagnosis of streptococcal septicemia was considered with a possible septic focus in the left foot. However, if this were so one would be forced to include a local lesion of the aortic valve because of the changing systolic murmur, the occurrence of an aortic systolic thrill, and the development of a diastolic murmur. Streptococcal septicemia can produce petechiae, but if so one would presume there would be pulmonary lesions as well, which were not present in our patient.

The finding of calcification in the aortic valve brings up consideration of its origin. Libman[18], has stated that calcification of the aortic valve may occur as part of the healing process in subacute bacterial endocarditis. Reich[19], has reported such a case in a 41 year old female. It is extremely unlikely however, that calcification could have occurred in three and one-half months from the onset of the endocarditis in our case. More probably it represents an old rheumatic lesion. Christian[20], Dry and Willius[21], and Levine[22], believe calcareous aortic stenosis is due to a preceding rheumatic infection. Karsner and Koletsky[23], found only three of 40 cases where rheumatic fever was not associated with sclerosis of the aortic valve. We have evidence

then of an old rheumatic calcific aortic valve as the site of the acute bacterial endocarditis.

The occurrance of a typical severe, acute rheumatoid arthritis in this patient brings up the relation between this disease and preceding streptococcal infection. We cannot be certain that this patient had not had arthritis before this illness. She admitted vague joint pains but denied any acute illness. The presence of a calcified aortic valve at age 53 would indicate that she had had a previous rheumatic fever. She at least had a recurrence of her arthritis. It was severe and is still active five months after the onset of her illness. Perhaps rheumatoid arthritis or rheumatic fever may become a complication in arrested cases of hemolytic streptococcal endocarditis. It is also possible that she had rheumatic fever and rheumatoid arthritis together as a result of her streptococcal infection. This possibility is suggested by the occurrence of a prolonged P-R interval late in the course of her illness. One electrocardiogram made during digitalis therapy showed a prolonged P-R interval presumed due to digitalis. Over two months after digitalis was stopped the P-R interval had shortened to 0.20 seconds. It then increased to 0.24 seconds, and one week later had shortened to 0.22 seconds. White[24], states that prolongation of the P-R interval does occur in acute bacterial endocarditis. However, at the time that statement was written only rare patients lived as long as this one and presumably he referred to the period of the acute illness. Boots and McCollom[25], describe cases with the typical joint findings of rheumatoid arthritis which they consider as chronic rheumatic fever. These patients show high antistreptolysin titers but the serum does not agglutinate hemolytic streptococci. Our patient with electrocardiographic signs of cardiac involvement and rheumatoid arthritis might fit into their group. However, the return of the antistreptolysin titer to a normal level with continued arthritic activity does not fit their criteria and is not usual in acute rheumatic fever.

This patient received a total of 22,629,000 units of penicillin over a period of 72 days. There were three reasons for such large amounts and the long period of therapy. First was the in vitro sensitivity test of the organism which showed it to be resistant to sulfadiazine in very high concentrations. The resistance tests to penicillin showed a higher degree of resistance than that of any previous hemolytic streptococcus tested in our laboratory. The tests indicated that to control the infection a blood level of 0.07 units per cc. of penicillin had to be maintained. Constant intramuscular drip administration caused local and general reactions and had to be discontinued. Intermittent administration at two hour intervals was finally used. The second reason was the occurrence of embolic phenomena as late as the 52nd hospital day. There was no febrile reaction and presumably these were sterile emboli. The possibility of septic emboli causing continuation of the infection prompted us to continue therapy until embolic episodes seemed a remote possibility. The third reason was the difficulty in determining when the original endocarditis was quiescent. With the presence of a severe rheumatoid arthritis, which was adequate explanation for a low grade fever and elevated sedimentation rate, we could not be certain it was safe to eliminate the pencillin. We feel that the penicillin might have been stopped much sooner than it was in light of the later progress. Her elevated sedimentation rate and low grade anemia at the last visit can adequately be explained by an active rheumatoid arthritis but obviously a long period of observation is necessary to be assured that a low grade bacterial endocarditis is not present. However, we feel that this is unlikely particularly with the return of the antistreptolysin titer to a level of 166 units.

Meads, Harris, and Finland[4], emphasize the importance of early diagnosis and early intensive treatment in bacterial endocarditis to prevent damage to other vital organs by emboli and to minimize the damage to the heart valves. Christian[26], stated that the earlier a correct diagnosis of bacterial endocarditis is made, the greater the probability of cure by chemotherapy. Because of the more rapid course in acute bacterial endocarditis it is even more important in this disease to start therapy as soon as possible. Meads and his associates recommend treating all cases with persistant bacteremia as though they were potential cases of endocarditis. After "arrest" or "cure" the convalescence should be carefully managed as in any other acute cardiac condition. Embolic phenomena may occur after apparent recovery and endanger vital organs or

increase the valvular damage. Severe cardiac failure may follow such episodes. Inability to control the disease in some patients has been at least partially due to intractable heart failure following destruction of a valve leaflet.

It would appear that early diagnosis and early intensive penicillin therapy offers definite hope in this otherwise hopeless disease. Emphasis must be placed on the attempts to institute treatment before severe valve damage has occured, thus minimizing the permanent cardiac sequelae.

SUMMARY

A case is reported of acute hemolytic streptococcal endocarditis where arrest of the infection was brought about with massive penicillin therapy. The patient suffered, as a complication, an acute rheumatoid arthritis which is still active five months after the onset of her illness.

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# HYPERTENSION AND VERATRUM VIRIDE

## A Preliminary Study

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The effect of Veratrum Viride in lowering blood pressure was described as early as 1874[1]; however, little was know of its pharmacologic action. Haultain[2]; in 1914, investigated the drug and claimed that it lowers the blood pressure by 7 to 50 mm., slows the pulse, and increases diuresis. The classic opinion has attributed these effects to cardiac depression mainly through vagal stimulation. It was further thought that if slowing of the pulse was not obtained, then it was not beneficial.

Recently the pharmacodynamics of the drug have been re-investigated. In light of the newer knowledge of Veratrum Viride, this series of clinical observations were undertaken to determine the effect of the drug. The drug used was a biologically standardized preparation of the powdered whole plant. Previous reports in the literature have been made exclusively upon alcoholic extractions or parenteral solutions.

Veratrum Viride is not a simple product but contains a number of alkaloids. Thus the estimation of potency by direct alkloidal assay as done in the past was difficult. All this lent an atmosphere of confusion to the subject. A sur-

TABLE 1

| PATIENT | SEX | AGE (YRS.) | Pb. | Pa. | Pc. max. | Daily Dose Craw Units | Length of Treatment |
|---|---|---|---|---|---|---|---|
| T. | F | 49 | 165/110 | 146/82 | —19/—28 | 15 | 20 weeks |
| A. K. | F | 69 | 198/104 | 150/80 | —48/—24 | 30 | 60 weeks |
| J. P. B. | M | 53 | 182/118 | 168/98 | —14/—20 | 15 | 60 weeks |
| M. M. | F | 72 | 220/100 | 180/98 | —40/—2 | 30 | 28 weeks |
| W. G. | F | 34 | 158/88 | 120/82 | —38/—6 | 15 | 20 weeks |
| M. | F | 61 | 162/90 | 128/68 | —34/—22 | 15 | 30 weeks |
| W. T.* | F | 50 | 222/118 | 210/110 | —12/—8 | 15 | 4 weeks |
| E. R. M. | M | 33 | 162/102 | 132/84 | —30/—18 | 15 | 13 weeks |
| J. W. D. H. | M | 71 | 248/132 | 194/88 | —54/—44 | 15 | 37 weeks |
| T. | F | 67 | 176/100 | 150/88 | —26/—12 | 15 | 19 weeks |
| R. | F | 45 | 158/60 | 128/70 | —30/+10 | 15 | 20 weeks |
| R. | F | 44 | 180/112 | 180/112 | —0/—0 | 15 | 11 weeks |
| D. E. F. | M | 63 | 182/112 | 176/98 | —6/—14 | 15 | 60 weeks |
| M. B. | F | 48 | 220/118 | 188/100 | —32/—8 | 15 | 37 weeks |
| H. G.† | M | 31 | 180/120 | 180/114 | —0/—6 | 30 | 4 weeks |
| L. S. | F | 60 | 196/80 | 178/80 | —18/—0 | 30 | 56 weeks |
| B. B. | M | 62 | 202/122 | 162/108 | —40/—14 | 30 | 56 weeks |
| Y. | F | 63 | 175/90 | 140/82 | —35/—12 | 30 | 52 weeks |
| Y. | M | 66 | 180/90 | 152/80 | —28/—10 | 30 | 40 weeks |
| S. R. | F | 64 | 220/118 | 182/110 | —38/—8 | 15 | 51 weeks |
| E. P. | M | 36 | 165/110 | 150/108 | —15/—2 | 15 | 41 weeks |
| A. T. | F | 61 | 188/118 | 160/102 | —28/—6 | 30 | 60 weeks |
| F. E. F. | F | 60 | 180/115 | 180/115 | —0/—0 | | 38 weeks |
| A. E. | M | 45 | 180/118 | 180/116 | —0/—2 | | 28 weeks |
| N. G. | F | 50 | 185/100 | 156/80 | —29/—20 | 15 | 60 weeks |
| C. W. | F | 27 | 154/92 | 132/80 | —22/—12 | 15 | 9 weeks |
| C. S. | M | 46 | 204/114 | 178/100 | —26/—14 | 15 | 8 weeks |
| B. C. | F | 39 | 178/110 | 138/86 | —40/—24 | 15 | 24 weeks |
| V. H. | F | 46 | 160/94 | 146/82 | —14/—12 | 15 | 8 weeks |
| B. W. | F | 34 | 180/116 | 140/80 | —40/—36 | 15 | 45 weeks |

*Treatment discontinued
†patient died of uremia
Pb. — Pressure before Rx.
Pa. — Pressure after Rx.
Pc. — Maximum change in pressure.

vey of the standard textbooks shows a general agreement in that the blood pressure lowering effect of the drug is due to cardiac slowing. Medical opinion at the present time is being reviewed[3]. The role of vasodilatation in contributing to the fall of blood pressure has recieved attention by MacNider[4], Cramer[5], Bryant and Fleming[6]. The latter authors in using Veratrum Viride in eclampsia, believe that the principal action of the drug is vasodilatation. They conclude that its function is to obtain a generalized vasodilatation. Wilson and Smith[7], in their work on animals, found that Veratrum Viride increases the perfusion rate in isolated organs. It also caused a fall of blood pressure and an increase in size of the leg volume without perceptible change in cardiac action of anaesthetized vagotomized dogs.

This preliminary report is based on 30 cases of hypertension all of whom were treated with biologically standardized Veratrum Viride. These patients presented themselves with a myriad of complaints. Some knew they had hypertension; others were unaware of the fact. Most were found to have some evidence of renal damage, hematuria, albuminuria, hyalin, or granular casts. All had definite evidence of arteriosclerosis, from observation of the fundi, or had arteriolarnephrosclerosis. One case of malignant hypertension was observed. Three patients had suffered from coronary occlusion and one was found to have a bilateral pyelonephritis and a right hydronephrosis.

The age of the patients ranged from 27 to 72. The majority were over 50 and their combined average age was 51 years. At least three separate predrug blood pressure observations were obtained a few weeks apart, and an average was taken. The result was assumed to be the predrug level.

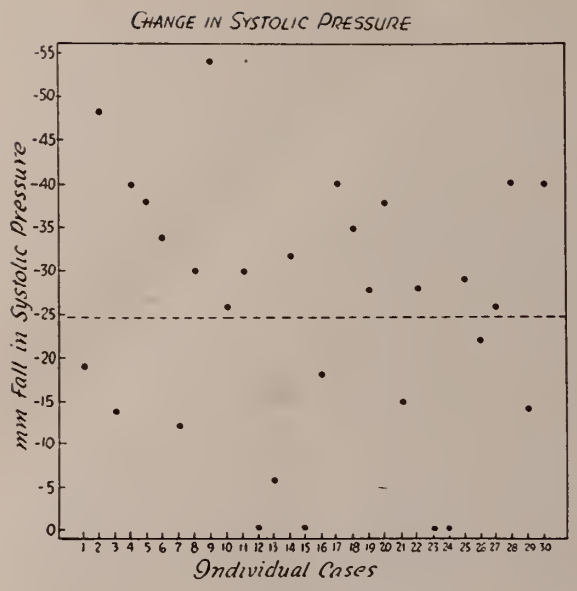



TABLE 2

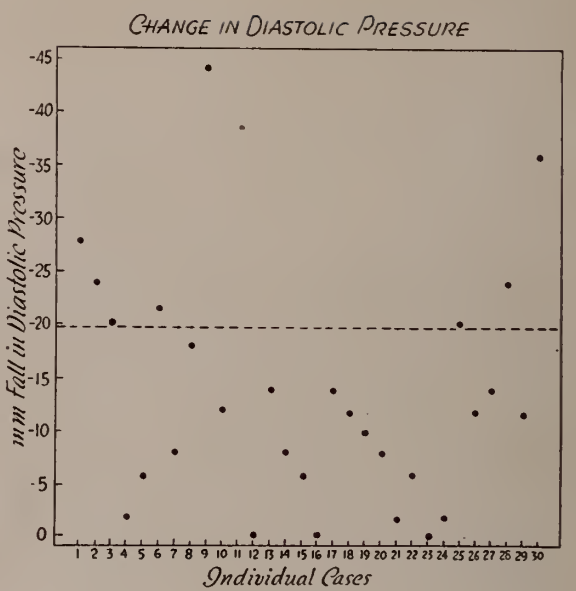



TABLE 3

| | |
|---|---|
| Predrug blood Pressure (Average) | Systolic 185.8 + 8.9<br>Diastolic 107.8 + 3.0 |
| Length of treatment | 4 weeks to 60 weeks<br>Average 33 weeks |

Table 1 is a list of the clinical material with all pertinent information about the patients.

Table 2 is a scatter chart and shows the falls obtained in the systolic blood pressure of the patient. At a glance one sees that most cases are above the 25mm. level. Table 3 is another scatter chart and shows the diastolic blood pressure fall. The greatest fall of systolic pressure was 54 mm. of mercury and that of diastolic 44 mm. of mercury. The average fall was systolic 25.8 + 3.1 and diastolic 13.7 + 2.4. The percentage of patients showing a fall in systolic pressure greater than 10 mm. was 83.3% and in diastolic 56.6%.

Sixty percent of all cases showed a fall of systolic pressure greater than 25 mm. but only 26.6% showed a diastolic fall of 20 mm. of mercury.

In a recent report by Weaver et al[9], the lowering of blood pressure was studied in its relationship to the administration of the various nitrate and organic compounds. The average fall in all cases was less than that observed in this report.

| | Sod. Nitrite | Manitol H 4 Nitrite | Veratrum Viride |
|---|---|---|---|
| % showing fall in systolic beyond 10 mm. | 64 | 44 | 83.3 |
| % showing fall in diastolic beyond 10 mm. | 19 | 31 | 56.6 |

Failure with Veratrum Viride was observed in 4 cases or 13.3% of the number observed. These patients exhibited far advanced renal disease; one died with uremia and the others had severe generalized arteriosclerosis and associated arteriolarnephrosclerosis. A few patients discontinued the drug and had a subsequent rise of blood pressure which was lowered by the resumption of treatment. The dosage of the drug varied from 15 to 30 Craw units per twenty-four hours. A bout of vomiting occured in one patient and an occipital headache was observed in another. In both cases relief was obtained by withdrawing the drug and giving small doses of atropine. From this series of 30 patients, preliminary evidence indicates that Veratrum Viride in the dose required to lower blood pressure in the hypertensive patient, does not affect either the cardiac rate, respiration, or temperature. No electrocardiographic changes were observed. Dosage had to be maintained at therapeutic levels.

The results obtained in this report on the treatment of hypertension with Veratrum Viride should be critically observed and cautiously entertained. So far no cumulative effects as occur with the thiocyantes have been observed with this preparation. Nor has a tolerance of the drug been found in these patients, as one sees with the nitrites and allied compounds.

(*Continued on page* 341)

# Industrial Health

Committee On Industrial Health — Jos. H. Chivers, Chm., 836 S. Michigan Ave., Chicago 5, Frank P. Hammond, H. A. Vonachen, R. I. Barickman, C. O. Sappington, Milton H. Kronenberg.

## THE URGENT NEED FOR BETTER LOCAL INDUSTRIAL HEALTH ORGANIZATION

C. M. Peterson, M.D.,
Secretary, Council on Industrial Health
American Medical Association

The essential elements in dependable health service for industry are:

1. A competent physician who takes genuine interest in applying the principles of preventive medicine, surgery and hygiene to employed groups and who is willing to devote regular hours to such service in the working environment.
2. Industrial nurses with proper preparation, acting under the physician's immediate supervision or under standing orders developed by him or by the committee on industrial health of the county medical society.
3. Industrial hygiene service directed at improvement of working environment and control of all unhealthful exposures, to be provided physicians and others with guidance and assistance from the specialized personnel in state and local bureaus of industrial hygiene.
4. A health program which should include:
   a. Prompt and dependable first aid, emergency and subsequent medical and surgical care for all industrial disability.
   b. Health conservation of employees through physical supervision and health education.
   c. Close correlation with family physicians and other community health agencies for early and proper management of nonoccupational sickness and injury.
   d. Good records of all causes of absence from work as a guide to the establishment of preventive measures.

### ORGANIZATION

The Council on Industrial Health is actively engaged in organizing committees on industrial health in the state medical societies and in all county medical societies located in areas where such a step is justified. We have recommended that the county medical society committee should contain representation from industrial practice, private practice, and the local health unit since these are the essential medical groups needed to supply the service. Obviously, the committee should understand the components of adequate service and be prepared to adjust them to existing medical and public health facilities and methods of community practice.

The committees, with local variations, will probably proceed as follows:

1. The committee in the county society should request instruction from the committee on industrial health in the state medical association and from the state division of industrial hygiene. Preferably, a preliminary conference should be held with representatives of these two agencies to establish:
   a. The lines of relationship and responsibility already existing between government, industry, labor and the medical profession.
   b. The principal industrial health problems of the community as a basis for remedial action.

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c. The proper organization and employment of local medical and health facilities.
d. Supplementary services which can be called on from sources outside the community itself.

The needs of small industry should be particularly stressed.

2. The names of all physicians now serving or willing to serve in industry should be determined. These physicians should be invited to attend a meeting at which the the results of the preliminary conference just described can be reported and general details of the program presented for discussion and adoption.
3. Conferences should be held with other essential professional groups, particularly industrial or public health nurses and industrial hygienists, in order that dependable arrangements for services provided by these groups may be made.
4. The county medical society committee should then request a conference with the executives or a representative committee of the local manufacturers' association, chamber of commerce or both to describe the program and to determine how the medical profession and the local health department can accelerate and improve production through appropriate health activity. Specifically, the following items should be discussed:
   a. The essentials of industrial health service as outlined.
   b. The health and economic benefits of such a service.
   c. Methods of supplying this service.
   d. Probable cost

   The committee of the manufacturers' association can well be asked to act permanently as advisor to the county medical society committee.
5. Active cooperation should be secured from local labor organizations both in respect to the conduct of medical services in the plant and to establish a program of health education in the community. Health education should emphasize particularly nonoccupational factors which are of importance to the health of workers — nutrition, housing, proper use of leisure time, recreation and other related activities. The committee representative of local labor organizations should be requested to assume a considerable share of responsibility for the health educational aspects of the program and should regularly act in an advisory capacity to the committee on industrial health of the medical society.
6. The next procedure should be an open meeting conducted jointly by the county medical society and the local manufacturers' association or chamber of commerce, to which employers, physicians, other professional agencies, representatives of labor and, in fact, the community at large, can be invited. This meeting will provide means for promoting the program widely throughout local industry.
7. Following preliminary organization, the activities of the county medical society's committee on industrial health will fall mainly under four major headings:
   a. Investigation of local causes of lost time in industry as a basis for necessary remedial service.
   b. Coordination of community industrial health facilities.
   c. Frequent education of the public about the benefits of an industrial health program.
   d. Continuous education of the medical profession as a means for elevating standards of industrial health service.

   In all other ways the committee should exercise that degree of initiative and leadership which will properly represent medicine's responsibilities and opportunities in this important field.

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COMMENT

I should like to invite the attention of the medical profession particularly to Dr. Carl M. Peterson's article.

The greatly increased awareness of all to the need for, and value of, a healthy worker will doubtless result in a demand for medical services in industry which will challenge the medical profession. Physicians with special training and experience in industrial medicine are few in number and all will be utilized. This number must be supplemented by the private practitioner, particularly in small industries if the problem and need are successfully met. This will require collaboration of the industrial medical practitioner, the private practitioner and

the governmental agencies, such as the Division of Industrial Hygiene of your State Department of Public Health. This collaboration can best be carried out through the state and county medical societies by the development of active committees on industrial health.

Dr. Peterson has presented a sound plan as a guide for committee action. Through his plan an excellent program can be developed in county medical societies with the assistance of the state society. In this way no industry in any community need lack adequate medical services.

I should like to add that the Illinois State Department of Public Health offers its services at all times in assisting these committees.

Roland R. Cross, M.D., Director,
Illinois State Department of Health.

## HYPERTENSION AND VERATRUM VIRIDE (Continued)

It is the opinion of the author at this time, that Veratrum Viride, as prepared and biologically assayed, has definite advantages over the drugs studied by Weaver et al[8]; eg., glyceroz trinitrate, sodium nitrite, erythrol tetranitrate and manitol hexanitrate in the treatment of hypertension and in our hands has demonstrated a wide margin of safety.

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## PENICILLIN MAY CAUSE NERVE INJURY

Two Navy doctors suggest that penicillin may cause injury to the nerves running to the surface of the body with resultant loss of sensation and muscular power, according to the October 12 issue of *The Journal of the American Medical Association.*

Comdr. Lawrence C. Kolb, (MC), U.S.N.R., and Lieut. Comdr. Seymour J. Gray, (MC), U.S.N.R., state that they observed this muscular weakness in seven patients treated with penicillin injections into the muscles at the U. S. Naval Hospital, National Naval Medical Center, Bethesda, Md.

The nerve injury observed in all the cases occurred from 10 to 21 days after the initial injection of penicillin. The number of penicillin injections into the muscles prior to these symptoms varied from 10 to 72.

The authors point out that complete recovery from the neuritis occurred within four months in five of the seven patients.

# News of the State

## PERSONALS · COMING EVENTS · MARRIAGES · DEATHS

### BUREAU COUNTY

Dr. Clarence Olson, Princeton, addressed the Bureau County Medical Society on November 12th, subject, "Diagnosis and Treatment of Non-Penetrating Injuries to the Pancreas."

### CHAMPAIGN COUNTY

Dr. Andrew C. Ivy, vice president in charge of the Chicago Professional Colleges of the University of Illinois College of Medicine, spoke on "Medical and Surgical Aspects of Jaundice" before the Champaign County Medical Society on November 14th.

### COOK COUNTY

Doctors Robert S. Berghoff and Herbert E. Schmitz addressed the Southern Illinois Medical Society at Anna in November.

Dr. Harry Olin spoke before the Emerald Avenue Presbyterian Church on November 19th, subject, "Cancer."

Dr. Robert R. Mustell took part in a round table discussion on "Socialized Medicine" at the University of Illinois College of Medicine on December 2nd.

Dr. J. H. Chivers addressed the Married People's Club, Brainerd Community Church on November 13, subject, "Socialized Medicine."

On Oct. 23, Dr. Andrew C. Ivy was guest of honor at a banquet given by former students and associates. A feature of the occasion was the proposal by Dr. Anton J. Carlson, a teacher of Dr. Ivy at the University of Chicago, to establish the Andrew C. Ivy Student Loan Fund at Northwestern University, where Dr. Ivy had been a member of the staff for twenty years until his recent appointment at the University of Illinois. Dr. Carlson contributed the first check for the creation of the fund.

Dr. H. K. Scatliff addressed the Physicians Fellowship Club Auxiliary in November, speaking on "Public Health and the Private Physician."

Dr. J. Roscoe Harry addressed the Austin Executives Club, Y.M.C.A. on December 10th. His subject was "The Business Man and His Stomach."

Dr. James H. Hutton spoke on "Safe Reducing" before the North Shore Registered Nurse Club on December 9th.

Dr. William H. Cassels presented the scientific program before the Stock Yards Branch of the Chicago Medical Society in November. He discussed "Anesthetic Emergencies."

Mr. Carl V. Moore, professor of Medicine, Washington University School of Medicine, St. Louis, and Dr. John D. Stewart, professor of surgery, University of Buffalo Medical School, addressed the Chicago Medical Society on December 11th. Dr. Moore spoke on "An Appraisal of Folic Acid for the Treatment of Anemia" and Dr. Stewart discussed "Hemoptysis."

Dr. Benjamin M. Kagan, recently released from service in the army, has been appointed director of the new Kundstadter Laboratories for Pediatric Research, Michael Reese Hospital. Dr. Kagan was from 1940 to 1942 an instructor in pediatrics at the Medical College of Virginia, Richmond, where he also engaged in private practice.

Dr. Willard O. Thompson is the new managing editor of the "Journal of Clinical Endocrinology," succeeding Dr. Kenneth W. Thompson, resigned.

The Chicago Urological Society held a meeting on October 24th at the Palmer House. The Eighteenth Annual William T. Belfield Memorial Lecture was given by Dr. Hugh J. Jewett, assistant professor of urology, Johns Hopkins University School of Medicine, Baltimore, subject, "Infiltrating Carcinoma of the Bladder: Importance of Accurate Pre-operative Classification in the Eventual Selection of Appropriate Treatment." A clinical meeting was held at the Cook County Hospital in the morning, the program was presented by the Urological Staff of Cook County Hospital.

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Dr. Samuel M. Feinberg addressed the American Pharmaceutical Manufacturers' Association on the subject of "Progress in Allergy Therapy" in New York on December 9th, as part of the program of a scientific award ceremony in honor of the Mayo Foundation.

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Dr. Herman L. Kretschmer gave a diagnostic clinic on "Differential Diagnosis and Treatment of Obstructions at the Neck of the Bladder" in Cleveland on October 16th, at the meeting of the Interstate Post Graduate Association of North America. During this session he was elected President-elect of the Association.

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The North Side Branch of the Chicago Medical Society held a meeting on December 5th at the Drake Hotel. Dr. Stanley P. Reimann, Director Research Institute, The Lankenau Hospital, Philadelphia, spoke on "The Methyl Group and Cirrhosis of the Liver" and Dr. V. S. Counseller, Head Section on Surgery, Mayo Clinic, Rochester, discussed "The Applications of Vaginal Hysterectomy."

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*Information Center on Alcoholism.* Plans are under way to open an information center on alcoholism in the loop by January 1 under the auspices of the newly organized Chicago Committee on Alcoholism. A survey will be made among hospitals to determine whether scientific treatment can be obtained and the center will serve as a referral agency. Later a broad research program will be undertaken, financed by contributions from private individuals and organizations. Temporary officers of the Chicago committee are Dr. Anton J. Carlson, University of Chicago, chairman; Walter O. Cromwell, Juvenile Protective Association, vice-chairman and Alexander Roptchan, Council of Social Agencies, secretary-treasurer.

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*State-Aided Diagnostic Clinic in Evanston.* The State Department of Public Health has announced the establishment of a new state-aided cancer diagnostic clinic at St. Francis Hospital, Evanston. The schedule of diagnostic meetings at this center is every Tuesday and Friday morning at 10. Owing to the high death rate from cancer and the great value of early diagnosis, the division of cancer control is making an effort to establish diagnostic clinics at convenient points throughout the state. The Evanston center makes the sixth so far established, the other five being in Chicago, Rockford, East St. Louis, Springfield and Champaign.

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*Available beds for Poliomyelitis.* Sixteen beds for convalescent patients were made available October 16 at the University of Illinois Research and Educational hospitals.

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*Speech and Hearing Program.* A new educational, research and clinical program in speech and hearing rehabilitation has been inaugurated by the University of Illinois College of Medicine. Herbert Koepp-Baker, Ph.D., recently released from the navy and formerly director of the Speech and Hearing Clinic at Pennsylvania State College, will serve as director and also as director of the new speech and rehabilitation division of the Illinois Eye and Ear Infirmary. In both the medical college and the infirmary the work will be supervised by Dr. Francis L. Lederer, head of the otolaryngology department and chief of that service in the eye and ear infirmary. Dr. Koepp-Baker's appointment, said to be the first of its kind in any major university, will immediately provide instruction and clinical experience in this highly specialized field for medical students, physicians and persons working in the closely correlated nonmedical branches of special education, psychology and social work. Both undergraduate and postgraduate instruction will be included in the educational program. On the postgraduate level ear, nose and throat specialists will be further trained in the correction of speech and hearing disabilities. In the nonmedical field professional speech therapists will be trained in the correction of defective hearing and speech. Clinical facilities at the university will be utilized in furthering an expanding research program.

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Dr. Curtis Lee Hall, Washington, D. C., was named president-elect of the U. S. chapter of the International College of Surgeons. The organization, at its 11th annual session, voted to establish its permanent home and library at Chicago and hold its annual meeting there in 1947.

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## DEWITT COUNTY

Dr. Charles W. Carter, Clinton, was honored by the DeWitt County Medical Society when he was presented with a certificate and a lapel pin

in recognition of this election as a member of the Fifty Year Club of the Illinois State Medical Society. Dr. Ralph Peairs of Normal, Councilor for the Fifth District, made the presentation.

### HENRY COUNTY

Dr. George F. O'Brien, Chicago, presented the scientific program before the Henry County Medical Society in November. He spoke on "Modern Treatment of Pneumonia."

### KANKAKEE COUNTY

Dr. William J. Pickett, Chicago, talked on "Vascular Surgery" before the Kankakee County Medical Society on November 12th.

### KNOX COUNTY

Final reports on receipts obtained in Knox County during the drive to provide funds for the American Cancer Society show a total of nearly $2,000 dollars contributed from various sources. One feature of the drive was the economy displayed by the county group which was sponsored by the Knox County Medical Society. No individual received remuneration in any form.

### LA SALLE COUNTY

Drs. Robert Keeton and Andrew C. Ivy presented a scientific program before La Salle County Medical Society on December 19th.

### McLEAN COUNTY

Dr. Charles N. Pease gave an illustrated talk on "Treatment of Fractures" before the McLean County Medical Society in November.

### MACOUPIN COUNTY

Drs. G. C. Otrich and L. W. Roth presented a program before the Macoupin County Medical Society on November 26th discussing "The Do's and Don'ts for the General Practitioner in Eye, Ear, Nose and Throat Work."

### MADISON COUNTY

Two members of the Madison County Medical Society were honored recently by a dinner and party at the Evergreen Gardens, Collinsville. They were Drs. E. C. Ferguson of Edwardsville and J. H. McIntosh of Alton. They were presented with the Fifty Year Club certificate and lapel button.

### MARION COUNTY

Dr. Paul B. Rabenneck, Nashville, addressed the Centralia Woman's Club on December 2nd speaking on "Medical Fallacies."

Dr. and Mrs. Mirza P. DuComb, Patoka, observed their fiftieth wedding anniversary August 31st.

Dr. Maurice T. Horsman has resumed his medical practice in Salem, Illinois.

### MORGAN COUNTY

Dr. George R. Bradley, of Jacksonville, and formerly a practicing physician in Waverly, was honored by the members of the Morgan County Medical Society, the event being in recognition of Dr. Bradley's fifty years in the practice of medicine. Dr. Andy Hall, of Mount Vernon, President of the Club, made the presentation of the certificate and lapel pin.

The Illinois State Medical Society reported a comprehensive detailed survey of the medical, dental, hospital and other health facilities for the care of children was under way in Illinois.

The survey is part of a nationwide study sponsored by the American Academy of Pediatrics to obtain dependable data on the care now available which will serve in the future planning for child health.

Members of a committee of the state society to cooperate with the academy include Dr. John F. Carey of Joliet, chairman; Dr. Gerald Cline, Bloomington; Dr. W. L. Crawford, Rockford; Dr. George L. Drennan, Jacksonville.

### PEORIA COUNTY

Dr. David W. Fey is the new president of the St. Francis Hospital Staff, Peoria, it has been announced. He succeeds Dr. Paul R. Dirkse. Dr. Fey served in World War II from April 5, 1941, until the summer of 1945, retiring with the rank of lieutenant-colonel, which rank he held three years.

### PIATT COUNTY

Dr. William Scott has begun the practice of medicine in Bement. He had practiced in Sullivan, Illinois, for six years before entering the navy in 1945. During his medical service, he spent 8 months overseas, most of that time in Japan.

### SANGAMON COUNTY

Dr. Robert M. Goodwin, formerly of Chicago, a dermatologist, has arrived in Springfield to take over the practice of the late Dr. Willard L. Michaelson.

### WHITESIDE COUNTY

Sterling Gyro club opened its 23rd crippled children's clinic November 20 at the Sterling

Public Hospital. In addition to the members of the Whiteside County Medical Society, an orthopedic specialist and a nurse were sent by the State Department of Public Health.

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Dr. Walter R. Tobin, Chicago, addressed the Whiteside County Medical Society presenting "The Management of the Ambulatory Cardiac" on December 5th at the Lincoln Hotel, Sterling.

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## WILL-GRUNDY COUNTIES

Dr. Carmen Scuderi has closed his office at Gardner and has limited his practice to the South Wilmington office.

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The following program has been arranged for the Will-Grundy County Medical Society:

December 13 — Dr. Herbert E. Landes — Clinical Significance of Gross Hematuria

January 9 — Dr. Leo P. A. Sweeney — Common Eye Conditions Seen by the General Practitioner

January 23 — Dr. George A. Hellmuth — Treatment of Common Heart Conditions.

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## WILLIAMSON COUNTY

The Williamson County Medical Society, host to the Five County Medical Society Organization in November, had an interesting scientific program. Dr. Robert B. Rutherford, Peoria, talked on "Diabetes" and Dr. J. B. Moore, Benton, discussed "Problems of General Surgery."

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## MARRIAGES

Naftula Izbicki to Miss Rose Malekow, both of Chicago, August 11th.

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## DEATHS

Jeremiah Frank Armstrong, Chicago; University of Illinois College of Medicine, 1912. Former secretary to Booker T. Washington. Was shot and killed in his office Nov. 2nd. He was 69 years of age.

John M. Axelson, retired, Wilmette; Bennett Medical College, 1900, Northwestern University Medical School, 1904. Staff member of the West Suburban Hospital for many years; served as a captain in the Medical Corps in World War I. Died November 11th in Swedish Covenant Hospital, aged 75.

Norman Copeland, Chicago; Chicago of Physicians and Surgeons, School of Medicine of the University of Illinois, 1908. Died July 21, aged 68.

Frank S. Davidson, Chicago; Rush Medical College, 1897. Formerly on the staff of Ravenswood and Alexian Brothers' Hospitals. Died Sept. 27, aged 71, of cardiovascular renal disease.

Homer Willard Davis, Alton; Washington University School of Medicine, 1900. Chief of surgery at the Alton Memorial Hospital and surgical consultant to St. Joseph's Hospital. Died Sept. 5th, aged 72, of carcinoma of the liver.

Harold K. Gibson, Chicago; Northwestern University Medical School, 1898. Had been practicing physician for 40 years and senior attending obstetrician at St. Luke's Hospital for 25 years. Died Oct. 24th, aged 70.

Byron G. S. Gronlund, Chicago; Hahnemann Medical College and Hospital, 1912. Had been a practicing physician in Chicago for 30 years. Died Oct. 27th in South Shore Hospital, aged 57.

Roger W. Hubbard, Chicago; University of Illinois College of Medicine, 1926. Had practiced in Chicago many years and was former resident of Kankakee. Died Oct. 15th of a stroke, aged 48.

Irvin F. Hummon, Oak Park; Chicago College of Medicine and Surgery, 1917. Died Sept. 26th, aged 72, of coronary occlusion and arteriosclerosis.

William J. Jayne, retired, Ingraham; Medical College of Physicians and Surgeons of Keokuk, Iowa, 1879. Had practiced medicine in Ingraham his entire life. Member of the "Fifty Year Club" for several years. Died of carcinoma of the throat June 18th at the age of 91.

John A. Kropacek, Chicago; Hahnemann Medical College 1912. Had been practicing physician and surgeon on the west side of Chicago and in Cicero for 33 years. Died at West Suburban Hospital, Sept. 29th, of injuries complicated by pneumonia. He was 58 years old.

Thomas J. Lamping, Chicago; Rush Medical College, 1901. Was a veteran of World War I. Had practiced medicine in Chicago many years before moving to Neenah, Wisconsin, recently. Died October 22nd in Wisconsin, aged 69.

George W. McFatrich, River Forest; Bennett Medical College, 1892. Founder and president of the Murine Co., Inc. Died in November, aged 76.

William C. Ocasek, Berwyn; University of Illinois College of Medicine, 1934. Was instructor in medicine at the School and a member of the teaching staff at Illinois Research and Educational Hospital. Died of a heart ailment, Nov. 11th, aged 39.

Otto Charles Pinc, Chicago; Rush Medical College, 1923. Died Nov. 9th, aged 46.

Joseph Scheurich, Philo; Barnes Medical College, St. Louis, 1898. On visiting staff of Mercy Hospital and Burnham City Hospital, Champaign, where he died Sept. 7, aged 73, of coronary disease.

Edwin M. Smith, Sr., Chicago; Northwestern University Medical School, 1886. Formerly professor of anatomy, Women's Medical College, Northwestern University Medical School. Died Oct. 30th, aged 85.

Peter Strofs, Chicago; University of Illinois College of Medicine, 1931. Instructor in surgery, University of Illinois and staff member at Hines Hospital. Died November 5th in Michael Reese Hospital, aged 43.

Hasseltine S. Walker, retired, Chicago; Northwestern University Woman's Medical School, 1893. Had specialized in eye, ear, nose and throat. Died Oct. 23rd, aged 76.

THOMAS F. WALSH, Chicago; Chicago Medical School, 1917. Died Sept. 14, aged 57.

THOMAS G. WALSH, Chicago; Rush Medical College, 1922. Former associate professor of Medicine at Rush. Died in St. Luke's Hospital, Nov. 4th, after suffering a heart attack on a street car. He was 51.

SYDNEY P. WAUD, Chicago; Northwestern University Medical School, 1936. Was former port surgeon of Bombay, India, for the Army Medical Corps. Was found dead in his car, Oct. 19th. He was 37 years of age.

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## MILLION DOLLAR GIFT FOR U. OF C. HOSPITAL

Gift of a million dollars by the Goldblatt Brothers Foundation to establish "The Nathan Goldblatt Memorial Hospital" as the center of the University of Chicago's extensive program of cancer treatment and research was announced by Ernest C. Colwell, president of the University.

As a clinical center, the hospital will be devoted exclusively to treatment of cancer and other neoplastic diseases. The hospital will be built on Ellis Avenue, just north of 59th Street, to connect with the surgical section of Billings Hospital of the University Clinics. The Nathan Goldblatt Memorial will be the only university hospital in the country with the entire staff engaged full-time in cancer treatment and research.

The hospital also will be the focus of the University of Chicago's Committee on Cancer and its associated Committee on Normal and Neoplastic Growth, which coordinate research on cancer in nine clinical and basic science departments. In addition to the present research facilities, significant additional resources will be added soon by the laboratories of the University's Institute of Radiobiology and Biophysics and its Institute of Nuclear Studies. Both institutes already have complete staffs.

These institutes, outgrowths of the work — including the world's first chain-reaction pile — done at the University on the atomic bomb during the war, will enter the promising field of cancer treatment and the research opened up by improved sources of high-energy radiations, and by the great increase in supply and forms of radioactive materials provided by the atomic "ovens."

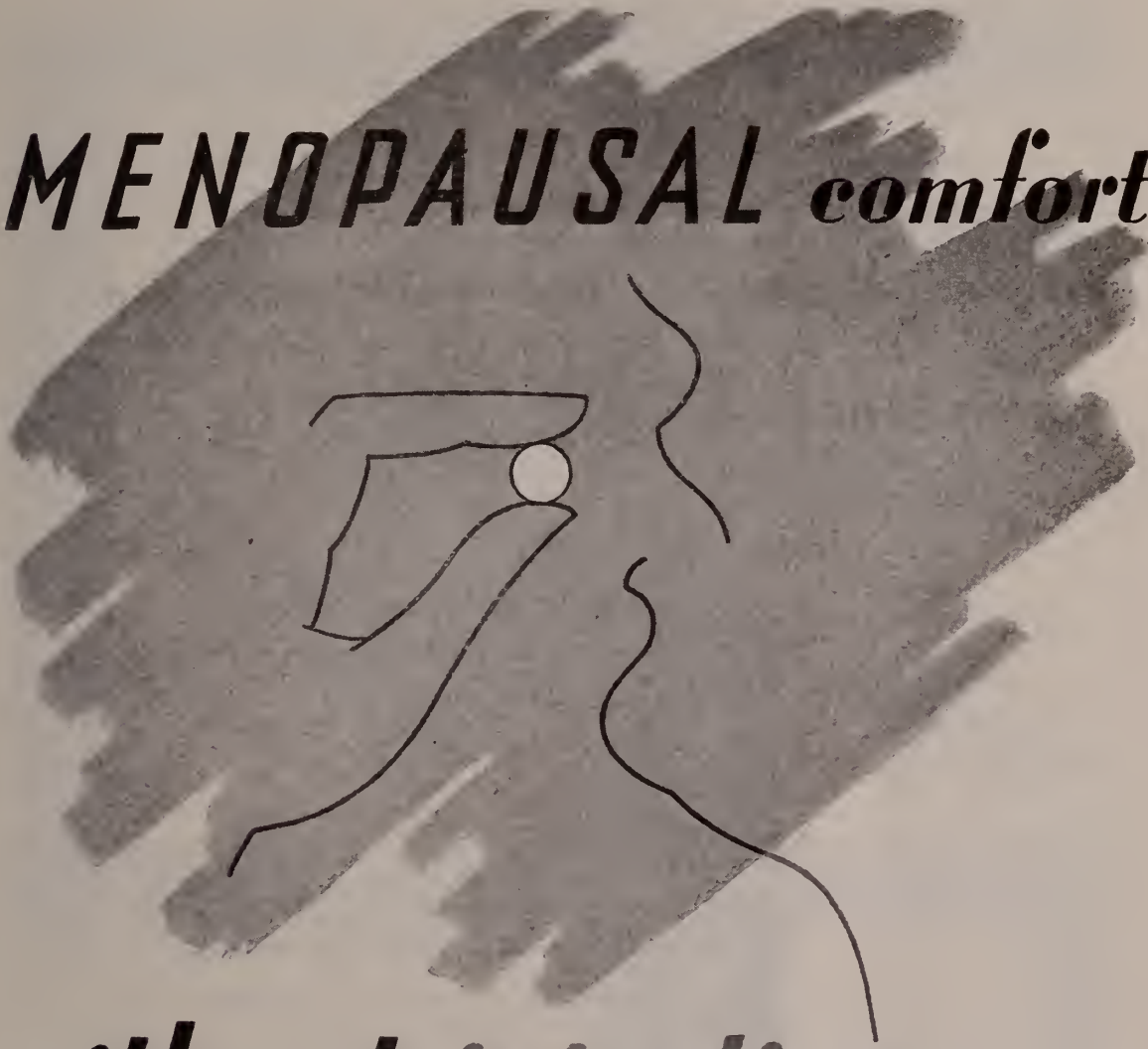
Among the tools which the Institutes will provide are a betatron of 100 million electron volts, and a large cyclotron, which will permit radiation of tumors at greater depth and with probable greater selectivity as between normal and diseased areas.

"The gift of the Nathan Goldblatt Memorial Hospital gives great impetus to the University's work on cancer," Mr. Colwell said in announcing the gift. "The clinical facilities for cancer are a valuable asset and will be of great service to those in need of treatment. An even more important result, however, is that the hospital as a teaching and research institution will be the focus of the broad cancer research effort which is being carried on by the University in the clinical and basic sciences."

If conditions permit, construction of the hospital will begin next spring. Immediate application for approval will be made to the Civilian Production Administration. Preliminary plans call for a six-story structure, which probably will be increased to seven floors, with basement and sub-basement, providing a minimum of 800,000 cubic feet and 50,500 square feet of floor space. Dimensions of the building have been tentatively set at 164 by 44 feet.

The hospital will provide at least 50 beds in single and two-bed rooms, together with the usual service features necessary for the care of patients. There also will be two operating rooms, an out-patient clinic, offices and research laboratories for the staff, diagnostic laboratories, administrative quarters, reception rooms for patients and their relatives, and conference rooms for the staff and the scientists working under the Committee on Cancer and the Committee on Normal and Neoplastic Growth.

# MENOPAUSAL comfort



# without injections

The distressing complaints of the menopause can be promptly and effectively relieved by ORAL treatment with Lynoral. It provides highly potent, well-tolerated estrogen therapy at a cost so low that it can be prescribed even for patients of very restricted means. For Lynoral is the Roche-Organon brand of ethinyl estradiol which has "a potent estrogen effect...with greater economy;"[1] in fact, it produces a "definite therapeutic response"[1] in doses as low as one-fiftieth of a milligram! Available in 0.05 mg tablets (scored for convenient dosage adjustment), bottles of 30, 60, and 250. ROCHE-ORGANON, INC., Roche Park, Nutley 10, New Jersey.

(1) F. E. Harding, *Am. J. Obst. & Gynec.*, *48*:181, 1944




LYNORAL ROCHE-ORGANON

REG. U. S. PAT. OFF.

**"The sulfonamide drugs given orally are recognized as the most valuable single therapeutic measure**

***in severe infectious sore throats."***

*Weille, F. L.: M. Clin. North America 28:1115.*

***Eskadiazine . . .***

S.K.F.'s fluid sulfadiazine for oral use . . . is particularly indicated for patients with painfully inflamed throats because:



***Eskadiazine***
**is so much easier to swallow**
than bulky half-gram sulfadiazine tablets.



***Eskadiazine***
**is so outstandingly palatable**
that even infants and children actually like to take it.



***Eskadiazine***
**is so quickly absorbed**
that it provides desired serum levels 3 to 5 times more rapidly than tablets.

*Smith, Kline & French Laboratories, Philadelphia, Pa.*

# Rapid Immobilization




# Prolonged Barrier Action

"RAMSES"* Vaginal Jelly fully meets the requirements for a safe, dependable spermatocidal jelly. It contains an exclusive, effective spermatocidal agent incorporated in a new, adherent, gum base. It has been shown to occlude the cervix for as long as ten hours after coitus.

Tests conducted by an independent accredited laboratory establish that "RAMSES" Vaginal Jelly will immobilize sperm ten times faster than the minimum requirements set forth by medical authorities.

Laboratory and clinical tests demonstrate

- its freedom from irritating or toxic properties, and
- that its use reduces the incidence of pregnancy.

As no salts of heavy metals are employed in its formula, distress attributable to heavy-metal sensitivity is avoided.

"RAMSES" Vaginal Jelly is never advertised to the laity; it is offered for use under the guidance of the physician only. It is available through recognized pharmacies.

Complete literature will be sent to physicians on request.

**The word "RAMSES" is a registered trademark of Julius Schmid, Inc.*

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**VAGINAL JELLY**

*gynecological division*
**JULIUS SCHMID, INC.**
quality first since 1883
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VERTAVIS is a single agent, providing in each tablet 10 CRAW UNITS of the whole, powdered Veratrum Viride. The product is standardized biologically by the Craw Method of Daphnia Magna assay, an Irwin-Neisler research development.

Vertavis in essential hypertension effects a significant fall in blood pressure and relief of predominant symptoms. Clinical tests have been conducted continuously for over two years with few side reactions, however mild. Supplied in bottles of 100, 500, 1000. Literature on request.

IRWIN, NEISLER & CO. Decatur, Illinois

ANNOUNCING

vertavis

A NEW CLINICALLY TESTED PRODUCT



FOR CONTROL OF HYPERTENSION




# HYDROSULPHOSOL

## *for* BURNS

*It's the* **HEALING** *Time that Counts*

*With* **HYDROSULPHOSOL** *Therapy*

**3rd degree burns have healed in 23 days**

**2nd degree face burns have healed in 10 days**

**Grease burns on hand have healed in 24 hours**

**FAST HEALING** *means . . .*

ABSENCE OF INFECTION

LESS SCARRING

LESS LOST TIME

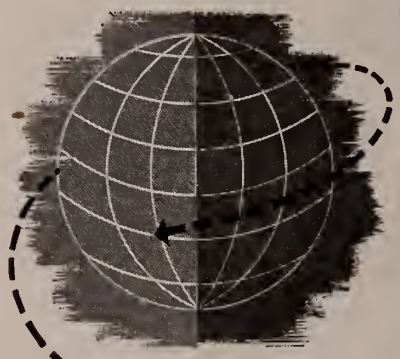
*Distributed by*

**REES-DAVIS DRUGS, INC.**

MERIDEN CONNECTICUT

*A Single Injection...*

and effective blood levels for



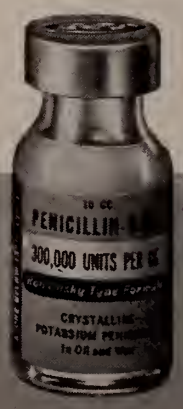
24 hours

CLINICALLY effective penicillin blood levels are readily produced and maintained for 24 hours by a single 1 cc. (300,000 units) intramuscular injection of Penicillin-C.S.C. Romansky Type. With the inconvenience of multiple daily injections overcome, the need for hospitalization is frequently obviated, since one visit daily by the physician suffices.

The relatively high penicillin blood levels produced by Penicillin-C.S.C. Romansky Type make this preparation applicable not only in the treatment of gonorrhea, but also in all other infectious diseases due to penicillin-sensitive organisms, except when unusually high doses are required, as in subacute bacterial endocarditis, or when specific administration is indicated, such as intrathecal injection in meningitis.

For rapid liquefaction of contents, vial may be immersed in boiling water without penicillin deterioration. Available in 10 cc.-size serum-type vials, each cc. containing 300,000 units of Penicillin-C.S.C. Crystalline Potassium Salt in a peanut oil-beeswax mixture.

**C.S.C. PHARMACEUTICALS**
A DIVISION OF
COMMERCIAL SOLVENTS CORPORATION
Terre Haute CSC Indiana, U.S.A.




**PENICILLIN-C.S.C.**
*Romansky Type*



TO *Streamline*" CREOSOTE THERAPY

Rx *Calcreose*

**PALATABLE • WELL TOLERATED • THERAPEUTICALLY EFFECTIVE**

The development of CALCREOSE (Maltbie) has, indeed, "smoothed the rough spots" in creosote therapy so frequently provocative heretofore of nausea and distress. • Moreover, CALCREOSE (calcium creosotate) exerts bactericidal and bacteriostatic action up to *three times as great* as that of creosote. • Thus, in providing all the well-known benefits of creosote in a *pleasant* and *palatable* form, CALCREOSE proves highly effective in many bronchial and respiratory affections . . . lessening cough, diminishing expectoration, reducing its purulency and deodorizing sputum. Also it tends to stimulate the appetite and improve the patient's general condition.

**AVAILABLE:** As tablets (4 gr.) in bottles of 100, 500, and 1000. COMPOUND SYRUP CALCREOSE in pint or gallon bottles.




*Calcreose*

THE MALTBIE CHEMICAL COMPANY • NEWARK, NEW JERSEY

# Tarbonis

**All the Theropeutic Volue of Tar in on Odorless, Greoseless, Non-Stoining, Non-Soiling, Vonishing-Type Creom.**

When secondary infection is not a complicating feature, Tarbonis remains the method of choice for the treatment of the many skin lesions known to respond to tar. It provides 5% highly active liquor carbonis detergens, together with menthol and lanolin, in a greaseless, odorless, stainless vanishing cream base. Tarbonis is specifically indicated in eczema (including the infantile and atopic varieties), psoriasis, ringworm, occupational dermatoses, folliculitis, seborrheic dermatitis, intertrigo, pityriasis, varicose ulcers, contact dermatitis, lichen planus, ulcus hypostaticum.




## THE TARBONIS COMPANY

**4300 EUCLID AVENUE • CLEVELAND 3, OHIO**

# Sul-Tarbonis




**A Rational Combination, Effective in Many Heretofore Intractable Skin Conditions**

Sul-Tarbonis combines the well-established therapeutic efficacy of Tarbonis (Liquor Carbonis Detergens 5%) with the proven antibacterial actions of sulfathiazole (5%). It thus provides a rational effective means of treating impetigo contagiosa, chronic infectious eczematoid dermatitis, infected varicose and other chronic ulcers, infected tinea corporis and pedis, pyoderma, and all other types of infected cutaneous lesions. As emphasized by Kenney et al. (Kenney, E. L.; Pembroke, R. H.; Chatard, F. E., and Ziegler, J. M.: Sulfathiazole Ointment in the Treatment of Cutaneous Infections, J.A.M.A. 117:1415 (Oct. 25) 1941), this combination of sulfathiazole and liquor carbonis detergens (in ointment form) combats not only the underlying dermatologic lesion but the secondary infection as well.

***Physicions ore invited to send for literoture ond clinicol somple of both products***




**FOR DEPENDABLE ORAL ESTROGEN THERAPY**

In ESTINYL, a derivative of alpha-estradiol, the potency and smooth action characteristic of natural estrogens are linked together with the economy previously obtainable only with synthetic preparations. Small doses of this new oral estrogen alleviate menopausal symptoms rapidly and rarely cause side effects.

# *ESTINYL* *tablets*

DOSAGE: One ESTINYL Tablet of 0.05 mg. daily. In severe cases two and three tablets may be prescribed daily. Current practice is to administer ESTINYL for two weeks after which a rest period of a few days is allowed. Such cycles are repeated as long as required.

ESTINYL (ethinyl estradiol) Tablets of 0.05 mg. (pink) and 0.02 mg. (buff) in bottles of 100, 250 and 1.000 tablets.

Trade-Mark ESTINYL—Reg. U.S. Pat. Off.

CORPORATION • BLOOMFIELD, N. J.
IN CANADA, SCHERING CORPORATION LTD., MONTREAL

DUAL-PROCESSED FOR

*Greater nutrient availability...*

**...EASIER DIGESTIBILITY**
**...SMOOTHER TEXTURE**

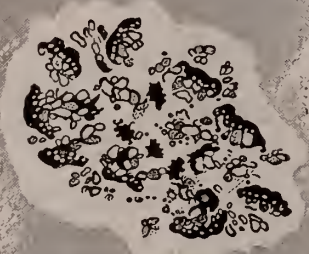
In the preparation of vegetables and fruits as baby foods, home-sieving and commercial straining produce a relatively fine subdivision of the cooked food. Under the microscope, foods so prepared are characterized largely by the predominance of readily identified intact food cells and by long coarse cellulose fibers.

To accomplish a still finer subdivision . . . one more suitable for early supplementation of the infant's milk diet . . . Libby places strained foods through an additional process—homogenization—and thus advantageously changes their physical structure. In this manner, the finest practicable subdivision of the vegetable cell is attained, and the contained nutriment becomes homogeneously dispersed throughout the mixture.

In consequence, Libby's Baby Foods present greater nutrient availability, easier digestibility, smoother texture; they can be bottle-fed as part of the "formula" without perceptibly retarding the rate of flow through a nipple opening of normal size; they may be fed . . . and are well tolerated . . . as early as the fifth week of life. And their cellulose content, comminuted to bland ultra-small particles, maintains an unimpaired "bulk" action.



Intact food cell, characteristic of strained foods. The nutriment is retained within the cellulase fiber capsule as a structural unit.



*After homogenization:* The capsule is ruptured and comminuted, the nutriment is released—subdivided—and dispersed, exposing a large surface area to the action of digestive juices.

**Libby, McNeill & Libby**
**Chicago 9, Illinois**

Beets • Carrots • Green Beans • Peas
Spinach • Vegetable Soup • Mixed Vegetables • Garden Vegetables • Liver Soup • Vegetables with Beef • Apples & Apricots • Apples & Prunes • Apple Sauce • Peaches • Peaches-Pears-Apricots • Prunes (With Pineapple Juice and Lemon Juice) • Custard Pudding

Vegetables with Bacon • Vegetables with Lamb • Apricots-Farina • Pears & Pineapple • Banana Pudding

The last five items not yet submitted to the Council on Foods and Nutrition. All other items Council Accepted.

*Libby's*

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

**HOMOGENIZED BABY FOODS**

# SUBJECT: "YOUR DOCTOR"
## AUDIENCE: 23 MILLION PEOPLE

**This is the 200th message published by Parke, Davis & Company in the interest of the medical profession. It appears this month in full color in LIFE and other leading national magazines.**

Some things you should know about **your doctor**

No. 200 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.



IN TIMES of distress, almost everyone turns to his doctor. But when things are going smoothly, some people are apt to take him pretty much for granted.

However, if you consider your doctor's service to you and to the country—if you consider the skills he must have, the sacrifices he must make, the hardships he must work under—then it isn't very easy to take him for granted.

To become a doctor usually requires three to four years of pre-medical education, four years of medical school, and another year or more as an interne. But this by no means represents the end of his training.

Do you realize how much time your doctor has to spend in continuing study—so he can bring you the benefits of all the latest medical advances?

*During a year the average American doctor devotes the equivalent of about a month to the study of medical books and journals and to attending medical meetings.*

It's an old story about how many patients a doctor has to see every day, how much of his time he devotes to charity, how many calls he has to make in the middle of the night. But did you ever think of it this way:

*When you leave your office or job, the chances are that you're free from business duties for another day. You can do whatever you feel like—you can dig in your garden, visit friends, have a quiet evening at home with your family, drop in at a movie, or go for a drive. But your doctor's work is never finished. He's always—every waking and sleeping moment—responsible for the patients under his care.*

Yes, it takes a lot of things to be a good doctor. It takes physical and nervous stamina. It takes patience. It takes great tact. It takes an understanding of people. It takes sound judgment. It takes unusual scientific and scholastic aptitude. It takes a sympathy for the unfortunate. Above all, it takes a spirit of humanitarianism and a sense of service.

*Tall order, isn't it? Yet thousands and thousands of American physicians have all these qualities—and more. They are outstanding men and women. America should never cease to be proud of them.*

Makers of medicines prescribed by physicians

**PARKE, DAVIS & CO.**

Research and Manufacturing Laboratories • Detroit 32, Michigan

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# why Dexedrine is so beneficial in menstrual dysfunction









*"The Central Nervous Stimulant of Choice"*

**Dexedrine** therapy not only alleviates the mental depression and psychogenic fatigue which ordinarily accompany dysmenorrhea; but also, through its marked amelioration of mood, beneficially alters the patient's reaction to pain.
*Smith, Kline & French Laboratories, Philadelphia, Pa.*

## Dexedrine Sulfate tablets

**(dextro-amphetamine sulfate, S.K.F.)**




# Truly, this is America . . . Saturday Night!

**"The feature picture? Starts about nine. Pretty good, too."**

**"I see Dr. Henry is still in his office."**

YES . . . that's Main . . . where Elm runs into it. And that's the main stream of our national life where the products of the field, factory and laboratory funnel through the shops to the homes of the happiest—and healthiest—people on earth.

Their good health is no accident. It is part of our national design . . . product of the world's top standard of living, and the newest in medical knowledge.

Thanks to the community physician, there is no gap between the medical laboratories and the health needs of Main and Elm. The American practitioner, trained in freedom's tradition and alert to the new, sees to that. He is the bridge between the laboratory and the patient's bedside.

More . . . he is a member of that great profession . . . the physician . . . on whose initiative depends the interchange of medical experience between himself and his colleagues.

IN the scientific Ciba laboratories at Summit, New Jersey, we produce many of the fine pharmaceuticals of today. But even our medical scientists would be helpless in bringing their discoveries to bear on our national health—were it not for the practitioner's spirit of free inquiry . . . unfettered initiative.

CIBA PHARMACEUTICAL PRODUCTS, INC.
SUMMIT NEW JERSEY

## CHILDREN BORN WITH SYPHILIS RESPOND WELL TO PENICILLIN TREATMENT

In a study of 61 children, two Atlanta physicians have found that penicillin is effective in the treatment of congenital syphilis.

Congenital syphilis — a term usually associated with children who are born with the disease — is transmitted to an embryo while it is still in the womb. The infected mother's blood carries the corkscrew-like spirochetes to the infant's body. Many or all of the embryonic organs are affected.

Drs. Joseph Yampolsky and Albert Heyman, who are from the Department of Pediatrics and Medicine of Grady Memorial Hospital and Emory University School of Medicine in Atlanta, used penicillin to treat the 61 syphilitic children, according to the October 19 issue of *The Journal of the American Medical Association.*

Thirty-two of the 61 children had simple infantile congenital syphilis. Twenty-three of the 32 responded satisfactorily under the penicillin treatment. "All 23 are clinically well, have normal spinal fluids and exhibit no clinical evidence of the disease," the authors say.

While three of the patients died, the authors believe that the fatalities were in no way related to the treatment. Two of the deaths "apparently resulted from an overwhelming syphilitic infection in premature and malnourished infants, while the third fatality remains unexplained."

In discussing the remaining 29 patients, the Atlanta doctors say that seven were suffering from acquired primary and secondary syphilis, while the others were treated for late forms of congenital syphilis.

In the seven cases of acquired syphilis, the doctors say the patients were treated with doses of penicillin comparable to those used in adults. "The syphilitic lesions healed promptly in every case and the spirochetes disappeared rapidly," *The Journal* article says, adding: "All of these children have been followed for at least six months.

"The results obtained with penicillin in the treatment of syphilis in children seem to depend on the nature and duration of the disease. Although penicillin appears to be effective in the treatment of infantile congenital syphilis and in early neurosyphilis, little or no response can be expected in the treatment of the late manifestations of this disease."

Drs. Yampolsky and Heyman say that while the optimum dosage of penicillin cannot be determined in such a small series of cases, "we believe that a total dose of penicillin of 100,000 units per kilogram of body weight is effective in the treatment of the majority of these cases."

Help Correct the Complicating Factor of Nutritional Failure with

B-NUTRON

Syrup ★ Capules

Bottles 4 - 8 - 16 oz. Bottles 40 - 100 Capules

B Complex and Iron Dual Dosage Forms

*Each teaspoonful B-Nutron Syrup (5 cc.) provides:*

Thiamine Chloride ($B_1$)... 2 mg. Niacinamide... 10 mg.
Riboflavin ($B_2$)... 0.5 mg. Ferrous Gluconate... 1 gr.
Pyridoxine ($B_6$)... 0.2 mg. Manganese Sod. Cit. N.F. VII... 1/4 gr.

B-Nutron Capules provide essentially the same formula for use when this form is more acceptable to the patient than a syrup.

INDICATIONS: Chronic Diseases ★ Pre and Post Operative Care ★ Pregnancy and Lactation ★ Infancy and Childhood ★ Convalescence and Restricted Diet.

NION




NION CORPORATION, LOS ANGELES 38, CALIF.

# "don't smoke"...

*IS ADVICE HARD FOR PATIENTS TO SWALLOW!*

May we suggest, instead, *SMOKE "PHILIP MORRIS"?* Tests* showed 3 out of every 4 cases of smokers' cough cleared on changing to PHILIP MORRIS. Why not observe the results for yourself?

*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

# P. R. N.

The Jocular Jingles of C. G. F.
by
Charles G. Farnum M. D.
Peoria, Ill.

### GOING! GOING!! GONE!!!

**Through long and dreary winter days depleting,**
**With ice and sleet and snow our daily greeting,**
**We freeze and shiver through each day,**
**The leaden skies bring deep dismay —**
**We've had our fill and we are now retreating.**

**Our migratory instinct now uprises,**
**Our conscience very promptly comprises,**
**The long gray road entices us**
**And that alone suffices us**
**To follow what our wanderlust devises.**

**We're going south where flowers are in profusion,**
**Where sun and azure skies bring gay illusion,**
**The weather there delights us,**
**A tawny beach invites us**
**To where we're safe from winter's bleak intrusion.**

### DECEMBER

December with its shorter, colder days
Reminds us of our post-meridian life;
Yet long and peaceful eves by firelight blaze
Afford surcease from hours of work and strife.
The juncos, sparrows, red birds, chickadees
Right merrily accept what winter sends,
While we, protesting bleak and nipping breeze,
Already long for days when winter ends.
With joy and song we hail the Christmas time,
The sweetest of illusions to remain,
For one brief space we rise to heights sublime,
Then promptly drop in former ruts again.
Hope must defeat experience, I fear,
To give one courage for another year.

### GERIATRIC JOCULARATIES

**I had not seen Uncle Timmy for a long time and was delighted to meet him on the street one day — a dried-up little man with many wrinkles but an alert merry look in his eyes.**

**I said, "Uncle Timmie I am glad to see you again. How are you and how have you been?"**

**"Fine," he replied. "Fine. I sleep like a baby. I eat like a horse. I ain't got an ache or a pain in me body. There's only one thing the matter with me."**

**"Well, Uncle Timmie," said I, "when a man has lived for more than eighty years and has only one thing wrong with him he is a fortunate person. What is this one thing?"**

**He leaned toward me and with a chuckle in his voice replied, "The only thing in the world the matter with me is I've had too many birthdays."**

### CHRISTMAS

Come now the days we think of friends
For Christmas time is here,
The houses all are lighted up
With signs of Christmas cheer.

The ground is covered white with snow,
Glad songs are in the air,
At home, at work we see the signs
Of friendship everywhere.

A christmas tree is in each house
And gifts are there galore:
We give the way the wise men gave
In ancient days of yore.

A host of cheery greetings come,
They bring a happy thrill;
And we in turn send messages
Of friendship and good will.

So P.R.N. sends each of you
A message that's not new,
"A Merry Gladsome Christmas Time
To All Of Yours and You."

### PATHOLOGICAL SONNET
### BURSITIS

**At first some twinges near the shoulder joint,**
**A thing I thought would quickly pass away,**
**But as the pain increased things seemed to point**
**Toward its having come for endless stay.**
**The pain grew worse. I could not use the arm;**
**To eat, to button clothes brought pain and grief,**
**Each changed position brought a new alarm**
**And nothing that was done gave me relief.**
**No diathermy, x-ray, countless pills,**
**Nor heat, massage nor hypos helped at all;**
**Each day and night for weeks a thing that kills**
**And all of life an agonizing pall.**
**Of all the things with which I've been acurst**
**I think deltoid bursitis is the worst.**

### QUARRELSOME QUATRAINS

**Ich liebe rain im winter**
**For wann es kommt it goes,**
**Es bleibt nicht to annoy uns,**
**Vie sleet und ice und snows.**

Sophistes, the Seer saith, "My son, search not for that which is new for it is not. Remember ye, that which hath been is now, and that which is to be hath already been."



# EFFECTIVES . . . but not cure-alls

Modern therapeutics support the premise that no single medication will successfully combat all ear conditions. For that reason . . . DOHO, specialists in the development of effective ear medications . . . offer

## Auralgan

**IN ACUTE OTITIS MEDIA**

When pain, fever, edema, leucocytosis, sense of fullness and impaired hearing are present—AURALGAN by its potent decongestant, dehydrating and analgesic action provides effective relief of pain and inflammation.

## O-TOS-MO-SAN

**IN CHRONIC SUPPURATIVE OTITIS MEDIA**

O-TOS-MO-SAN provides a new Sulfa combination of Sulfathiazole and Urea in Auralgan Glycerol (DOHO) base, completely water-free and having the highest specific gravity obtainable — scientifically developed.

O-TOS-MO-SAN exerts a powerful solvent action on protein matter . . . liquefies and dissolves exuberant granulation tissue . . . cleanses and deodorizes the site of infection . . . and tends to exhilarate normal tissue healing in the effective control of chronic suppurative Otitis Media. Excellent results have also been obtained in furunculosis of the external ear canal.

*Write for Literature and Samples*

**NOTE:**

Where there is an intact ear drum, neither Sulfonamides nor Urea are effective . . . and under these conditions AURALGAN is indicated.

**WARNING!**

The indiscriminate use of the Sulfonamides should be avoided—so that infectious organisms do not become "sulfa-fast" or patients "sensitive" to Sulfa.

**THE DOHO CHEMICAL CORPORATION**

New York 13, N. Y. · Montreal · London

# Physical Medicine Abstracts

John S. Coulter, M.D.

## TREATMENT OF TUBERCULOSIS OF THE LARYNX AN EVALUATION

William F. Hulse, M.D., Cleveland

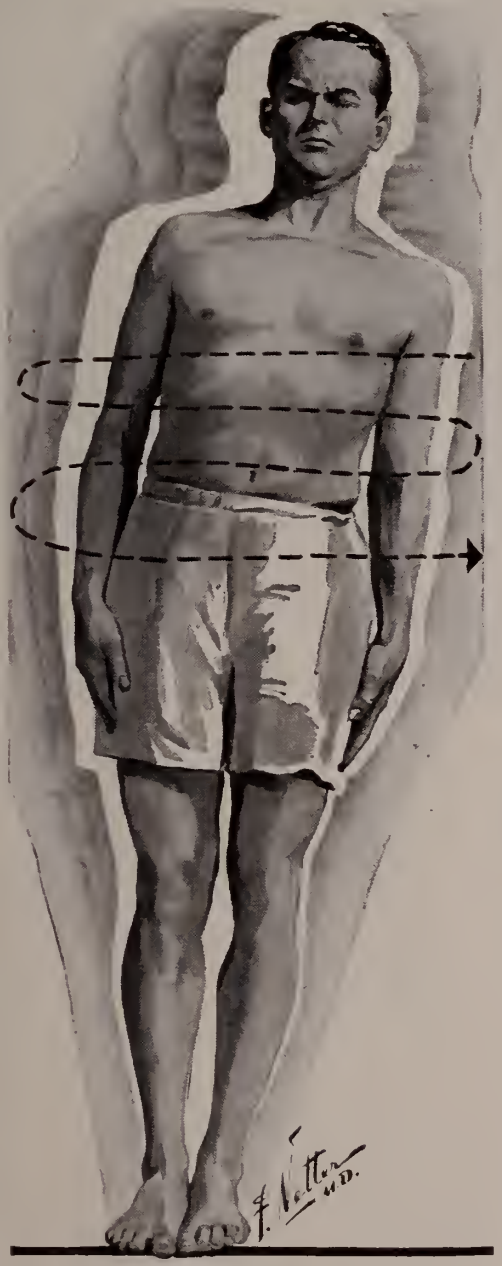
In ARCHIVES OF OTOLARYNGOLOGY, 43:6:578 June 1946

Ultraviolet ray therapy has long enjoyed extensive popularity in the general field of tuberculosis. In an earlier day it was considered as absolutely essential, regardless of the type of disease which was present. Before present day concepts of tuberculosis therapy were established, sunlight and a nurtitious diet share the only therapeutic halo available. Modern therapeutic measures have somewhat dimmed the luster of these two factors. Actually, certain types of pulmonary tuberculosis are probably rendered worse by irradiation. The use of ultraviolet rays is contraindicated in the acute exudative type of pulmonary or laryngeal tuberculosis. The use of ultraviolet rays, either natural or artificial, has until recently been widely accepted as a somewhat exalted therapeutic measure in laryngeal tuberculosis, and the various contrivances which were used to pipe the rays to the seat of the trouble were ingenious, though there probably was little benefit derived therefrom. It is doubtful whether under the very best of conditions more than a small fraction of the rays ever survived the trip through the various contours of the hypopharynx. Since ultraviolet rays are capable of penetrating only a depth of a few millimeters, those which did reach their destination left the actual seat of trouble largely undisturbed. Generalized exposure to ultraviolet rays has come to be accepted by many as being most beneficial in extrapulmonary tuberculosis, and I assume that laryngeal tuberculosis probably received some tangible aid from its use. It should be regarded solely as a supportive measure and nothing more.

Far out in front in the modern methods of attack on laryngeal tuberculosis is electrocautery. After this method was developed and recognized it superseded all others for a decade or more. At the zenith of its popularity it was considered to be appropriate for all forms of laryngeal tuberculosis until more modern concepts of pulmonary therapy were developed. It has been recognized for some time that most infections in the body will do much better after an operative procedure if it is feasible to permit the body wall off the infection to the greatest extent which good judgment will allow. If the body is not able to produce such a response, then cautery will be of no avail. If cautery is instituted before this has taken place, its employment may be expected to be expected to be disappointing not only from the standpoint of eradication of the disease but also from that of physiologic function. A considerable number of patients are to be seen today whose general physicial condition is functionally far superior to their laryngeal status, and this I believe to be the result in the vast majority of instances of inopportune or overenthusiastic cauterization or both.

Electrocautery may be said to have two main functions. The first is the destruction of diseased tissues and the second a local stimulation of tissues due to the resultant hyperemia. Just what part each plays in a given case cannot be determined with any degree of accuracy.

(Continued on page 62)



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## PHYSICAL MEDICINE (Continued)

## HYPERPYREXIA IN TREATMENT OF OCULAR CONDITIONS DUE TO SYPHILIS

Harry C. Knight, M.D., Surgeon,
U. S. Public Health Service and
Walter S. Schachat, M.D., Asst. Surgeon (R)
U. S. Public Health Service, New Orleans, La.

In ARCHIVES OF OPHTALMOLOGY, 35:3:271
March 1946

The induction of fever has been used by ophthalmologists in the treatment of various ocular conditions for many years. According to Cordes, the usual methods of fever therapy applicable to ophthalmology include:

1. Parenteral and intramuscular injections of foreign proteins
   - A. Native proteins (milk)
     - (1) Caseins (Yatren-Casein, Caseosan, Alobintin, Perprotasin and Aolan)
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   - B. Protein split products (peptone-albumose, proteoses, pepsin)
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   - E. Vaccines — mainly typhoid
   - F. Typhoid antigen
   - G. Bacterial extracts (Coley's mixed toxins, Omnadin)
2. Malarial therapy
3. Physical means
   - A. High frequency methods
     - (1) Diathermy
     - (2) Radiothermy (short wave)
     - (3) Inductothermy
   - B. Kettering Hypertherm

There are presented 35 cases of syphilitic ocular conditions in which specific antisyphilitic chemotherapy, the usual ophthalmic therapeutic measures and the Kettering Hypertherm were employed.

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(Continued on page 64)



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## PHYSICAL MEDICINE (Continued)

In the treatment of syphilitic choroiditis, this method of artificial induced fever therapy is valuable, particularly so when the lesions are fresh. It was employed in 6 cases of the acute form and resulted in decided improvement in 4, or 67 per cent. In the other 2 cases old, quiescent lesions were present.

The method is especially valuable when employed in the treatment of the form of acute iritis associated with secondary syphilis and affords a rapid form of treatment of this condition. Six cases of this type appeared in our series, in all of which excellent therapeutic results were obtained.

The method is definitely beneficial in the treatment of syphilitic interstitial keratitis, and it is most helpful in alleviating the severe pain and photophobia which are often associated with this condition.

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### ANKYLOSING SPONDYLITIS: ITS ETIOLOGY AND PATHOLOGY

C. W. Buckley
In ANNALS OF RHEUMATIC DISEASE, LONDON, 5:49
December 1945
Abstracted in
JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 131:16:1391
August 17, 1946

Buckley discusses the etiology and pathology of ankylosing spondylitis in the light of Batson's work on the venuous circulation from the prostatic plexus. The influence of phosphatase on bone resorption and redeposition is described, and the possibility of a toxin from the prostate influencing this process is considered. *The bone changes in rheumatoid arthritis, spondylitis and rickets are compared, and the conclusion is drawn that ankylosing spondylitis is not a form of arthritis but a toxic osteopathy.* The possible influence of sex hormones is discussed and found to be "not proven" but calling for further investigation. The importance of the dates of union of the epiphyses and the bearing of this on the disease is mentioned; the effect of the age at onset of the prognosis in the light of the pathologic condition is pointed out. Further investigation is urgently required in view of the great increase in the incidence of the disease, particu-

(Continued on page 66)



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PHYSICAL MEDICINE (Continued)

larly in those cases which do not conform strictly to the classic pattern.

## BRUCELLOSIS ADVANCES IN DIAGNOSIS AND TREATMENT

Harold J. Harris, M.D., New York
In JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 131:18:1485
August 31, 1946

The conservative treatment of accessible localized infection such as that in the oviducts is successful in a large percentage of cases. Pelvic short wave diathermy using temperatures near the upper limit of tolerance and safety is usually effective in bringing about resolution. It is used concomitantly with Brucella abortus vaccine therapy, neither method alone having been proved to be adequate. Use of the Bierman type of metal vaginal electrode (or Gottesman's modification), with thermometer temperatures as high as 108 F. for periods of from thirty to forty-five minutes, three to six times weekly, with a pad or belt electrode over the anterior portion of the abdomen or beneath the treatment table rather than the use of the usual through and through technic seems essential. One or more course of from twelve to fifteen treatments each may be needed. The method often is also applicable to cholecystitis of Brucella origin. Its use in splenitis has not been evaluated.

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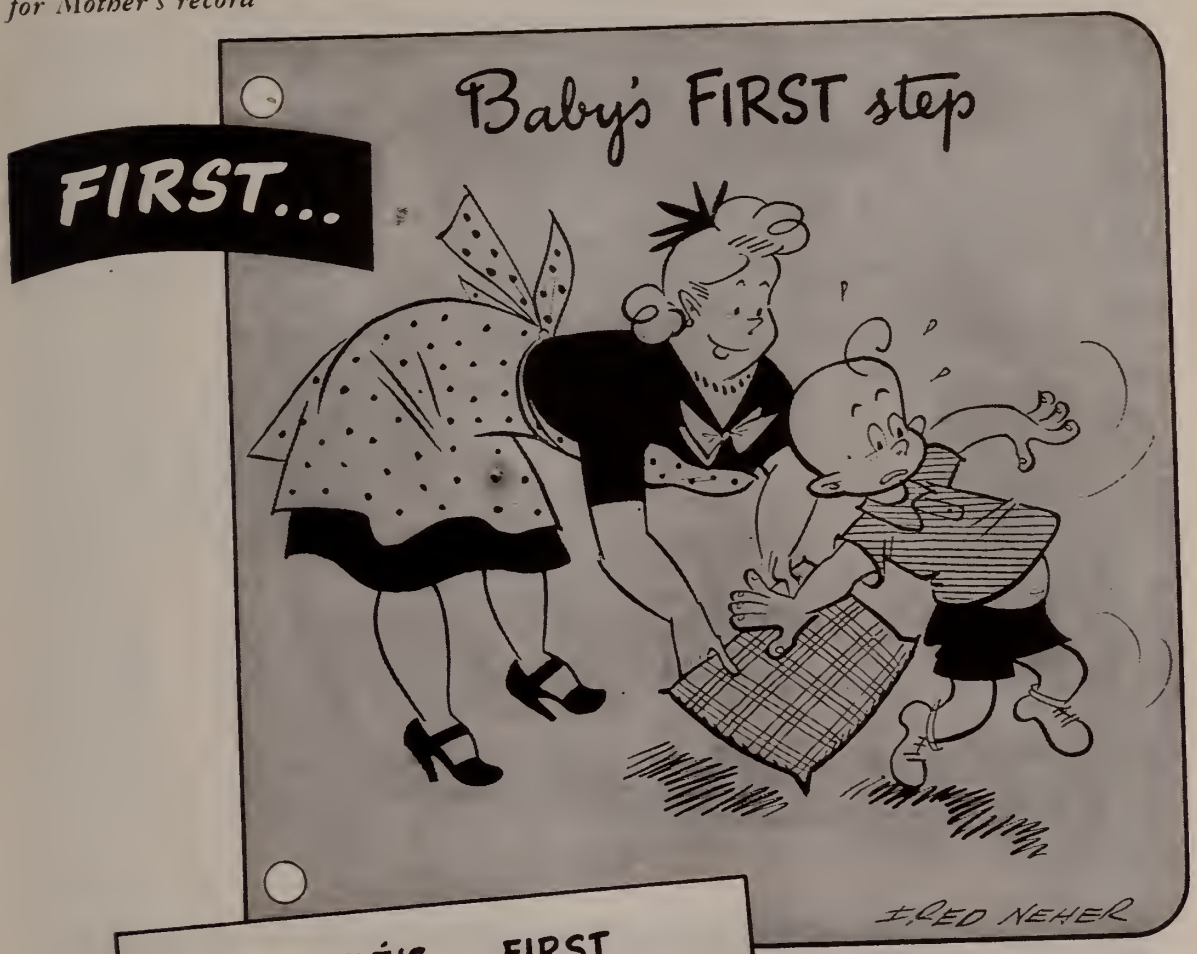
Philip J. Jacoby, New York City
In MODERN HOSPITAL, 67:3:60
September 1946

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# Book Reviews

TREATMENT IN GENERAL PRACTICE. By Harry Beckman, M.D., Professor of Pharmacology, Marquette University School of Medicine, Milwaukee, Wisconsin. Fifth Edition, Reset 1070 pages, illustrated Philadelphia and London: W. B. Saunders Company. 1945. Price $10.00.

The fact that this is the fifth edition of Treatment in General Practice in a period of fifteen years speaks well, indeed, for the popularity of the book. Dr. Beckman, long a teacher of pharmacology, states frankly that he writes as he teaches, and endeavors to give the essentials of treatment of the various disorders of the human family according to general-established principles, and in keeping with the ever-changing trends in medical practice.

During and following the late world war, there have been many changes in the practice of medicine and the treatment of disease; consequently in this present fifth edition of Dr. Beckman's book, the reader will find much that is new, and many sections of the book have been completely rewritten in keeping with the ever-changing trends. The author apologizes for the size of the book, 1070 pages, yet he has endeavored to cover the entire field of medicine and even with elimination of many controversial matters pertaining to treatment, a a book of this type to be complete, cannot be made the size of a pocket manual.

The use of the sulfa drugs and the antibiotics are mentioned in many sections of the book as would be expected, as so many indications for their use are recognized today in the general practice of medicine. To enumerate the additions in this present volume alone, would require more space than is usually permitted in a book review. The chapter on Burns, Shock, Crush and Blast Syndromes will be of interest to everyone reading this book or having it available as a handy reference work. He has given much consideration to the general care in major burns in keeping with the experience gained through the recent war when ideas concerning burn treatment and mortality following burns were changed so materially. The early and proper cleansing, followed by the use of compression bandages with the primary treatment of shock, are described in much detail. Likewise the modern treatment of shock is carefully considered, and brought up to date.

There is much that is new in this volume, and it should be in the hands of physicians everywhere, and probably will be used as freely as any book in the present-day medical library.

(Continued on page 72)



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## BOOK REVIEWS (Continued)

PRINCIPLES OF HEMATOLOGY. With 106 Illustrative Cases, and 167 illustrations. Including 173 Original Photomicrographs and 95 Original Charts and Drawings. By Russell L. Haden, M.A. M.D., Chief of the Medical Division of the Cleveland Clinic, Cleveland, Ohio. Formerly Professor of Experimental Medicine in the University of Kansas School of Medicine, Kansas City, Kansas. Third Edition, Thoroughly Revised, Lea & Febiger, Philadelphia, 1946. Price $5.00.

This is the third edition of a previously popular book, written especially for the student and the physician to simplify the study of blood disorders. Like all other branches of medicine, hematology has made a remarkable advancement since the last edition of the book was released. Consequently it has been entirely reset with some material in the previous edition left out, and many additions made a part of this book. It has been brought entirely up to date and in accordance with the present-day trends in the field of hematology.

Dr. Haden has endeavored to cover an important and extensive field in one relatively small volume, and gives in considerable detail the essentials to aid the physician in diagnosing many of these blood dyscrasias.

The examination of bone marrow is an important addition to this edition and its technic and study is well worth the cost of the book to any physician for bone marrow examinations are so essential in the proper study of the blood and in diagnosing of many blood dyscrasias. The technic of sternal puncture is described clearly, yet in such detail as to make the procedure an easy one. The importance of platelet counts in all hemorrhagic states is well brought out, and it is a must in these conditions.

The author gives the technic of blood examinations in much detail, making it much easier for the physician who makes them less frequently in his practice to know what should be done and permit him to develop his own technic. A considerable amount of space is devoted to considerations of granulocytes, and realizing their importance in present-day blood dyscrasias. This is a most interesting and highly important part of the book. With many of the newer therapeutic agents in use today, and with frequent blood examinations essential to check more carefully side reactions, every physician should become familiar with alteration in granulocytes and the findings of granulocytosis.

The clinical classification of anemia is likewise an interesting feature of the book, this being followed by chapters on the various types of anemias seen in present-day practice. The author's discussion of splenectomy, its indications and contraindications likewise will be of much interest to the reader; the functions of the spleen are also given in much detail.

This book will be of interest to physicians everywhere, written by an outstanding hematologist not for hematologists, but for the student and physician, it should indeed simplify the study of blood disorders, and stimulate on the part of the average reader, a desire


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PENICILLIN: Its Practical Application. Under the General Editorship of Professor Sir Alexander Fleming, M.B., B.S., F.R.C.P., F.R.C.S., F.R.S. Professor of Bacteriology in the University of London, St. Mary's Hospital, London. The Blakiston Company, Philadelphia. 1946. Price $7.00.

The book, although edited by Doctor Fleming, is actually composed of a series of articles prepared by a number of authorities on different aspects of penicillin. Consequently it is not a continuous textbook but a series of independent contributions on this highly important subject. Doctor Fleming has been asked to write the entire book but was unable to do so as his chief interest has been in the laboratory basic work which led to the general use of penicillin. He consented to edit the work not as a complete text on the subject, but in an effort to give to the medical profession of the world, a resumé of work which has been done, and to give to the physicians information as to how the preparation can be used to the best advantage.

Doctor Fleming tells the story of the history and development of penicillin (the name given by himself to the product in 1929) the term antibiotic, antibacterial substances produced by living organisms was first used in 1938. Fleming also gives the general rules for

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## BOOK REVIEWS (Continued)

penicillin treatment showing the indications and limitations.

Other contributors give the information relative to the chemistry and manufacture of penicillin, methods by which it is manufactures, etc., paying great tribute to the pharmaceutical houses in the United States which so rapidly produced the drug to make it more readily available; and other pertinent data relative to the control and methods of assay.

Methods of administration are described in detail presenting the method of choice in many conditions in which it has been indicated. As would be expected the inhalation methods of using penicillin appear in this section. Types of cases for which it is indicated appear, with a number of interesting case records which will be of assistance to physicians in general. The section on bacterial endocarditis shows that when first used, penicillin appeared of doubtful value, but as time went on and methods of administration, intervals between injections, and proper dosage were determined, more statistics were released showing that it is of much value in treating this baffling disease.

The importance of early and adequate treatment is well brought out. It is the general opinion now that a daily dosage of 500,000 units for 28 days gives fewer relapses and better results in bacterial endocarditis.

The use of penicillin in chest infections and in chest surgery is carefully described. Another interesting section pertains to use in osteomyelitis. It seems quite probable that statements made in 1943 by Sir Howard and Lady Florey that when treated early and intensively with penicillin, osteomyelitis would not require surgical intervention. General care of these conditions is well discussed and will be of much interest to the general practitioner.

Penicillin in other types of surgery and in several branches of medicine is likewise outlined. Its use in gonorrhoea and syphilis appears in two chapters. In syphilis (like other writers on the subject) the author states that it is still too early to tell the ultimate results, and it is generallly thought that the relapse rate will be about 15%. Most cases receive 2,400,000 units, as penicillin is not too plentiful in England, and it remains necessary to economize in its use. It still seems desirable to employ the arsenicals and bismuth supplementing the use of penicillin to get the lowest possible relapse rate.

Twenty-eight specialists endeavored to tell the medical profession how to use penicillin and secure the best results. Although admitting that this book does not cover the subject thoroughly as do many recent works on the subject, it does endeavor to give the indications, limitations, methods of choice in its administration and dosage. Well illustrated, the book should be widely used in the United States, and physicians should buy and read it.

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HOWELL'S TEXTBOOK OF PHYSIOLOGY. (Fifteenth Edition) Edited by John F. Fulton, M.D., Sterling



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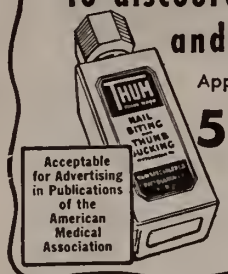
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Professor of Physiology, Yale University School of Medicine. 1304 pages with 507 illustrations. Philadelphia and London. W. B. Saunders Company. 1946. Price $8.00.

This is the 15th edition of an ever-popular book on physiology, the first edition appearing in 1905. The present editior, Doctor Fulton, has a staff of contributors selected to aid him in the preparation. Many new chapters appear, while others have been rewritten in their entirety. Editors were selected for each of the ten sections and they were authorized to select additional physiologists as they saw fit to review individual chapters. Therefore it is quite obvious that in this present edition much care has been given to the necessary planning to make the book a successs.

Howell's Physiology for many years has been a standard work, popular as a text for the student, as well as a reference book for physicians and others interested in the subject. Many facts concerning physiology at high altitudes have been given consideration especially pertaining to the field of aviation medicine and the field of war medicine.

The book consists of 1304 pages with 507 illustrations and leaves but little to the imagination when pertinent data in the entire field of physiology is desired. We predict a long and continued interest in this volume and it should be "a book of choice" in its field for years to come. The present editor is to be congratulated upon the planning and the development and upon the selection of men outstanding in their individual fields

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## BOOK REVIEWS (Continued)

who were delegated the responsibility of preparing the text for the individual chapters.

# Books Received

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

HYGIENE: A Textbook for College Students on Physical and Mental Health From Personal and Public Aspects; By Florence L. Meredith, B.Sc., M.D., Fellow of the American Medical Association, American Public Health, and American Psychiatric Associations; Professor of Hygiene and Public Health, Tufts College. Fourth Edition. The Blakiston Company, Philadelphia, Toronto. 1946. Price $4.00.

THE DIAGNOSIS AND TREATMENT OF BRONCHIAL ASTHMA; By Leslie N. Gay, Ph.B., M.D., Assistant Professor of Medicine of the Johns Hopkins University School of Medicine. Director of the Allergy Clinic of the Johns Hopkins Hospital. With a Foreword by Warfield T. Longcope, A.B., M.D., Professor of Medicine of the Johns Hopkins University School of Medicine. Physician-in-Chief of the Johns Hopkins Hospital. The William & Wilkins Company, 1946. Price $5.00.

QUANTITIVE CLINICAL CHEMISTRY INTERPRETATIONS. (Vol. 1); By John P. Peters, M.D., M.A., Professor of Internal Medicine, Yale University School of Medicine and Donald D. Van Slyke, Ph.D., Sc.D., Member of the Rockefeller Institute for Medical Research. Second Edition. Baltimore, The Williams & Wilkins Company, 1946. Price $7.00.



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